MQAC CASE REVIEW DISPOSITION
Commission Meeting RCM Presentations

Respondent: Harris, William K **Case Number:** 2011-157968

Date Presented: 1/13/2011	RCM: Clower	License#: ☒MD/☐PA
Panel Chair: Cullen	Staff Attorney: Landreau	MQAC Clerk dn

PANEL A	Andison, Brantner, Burger, Clower, Concannon, Cullen, Elders, Green, Johnson, Pattison, Winslow
PANEL B	Cvitanovic, Dore, Gotthold, Harder, Harvey, Hensley, Hopkins, Marsh, Ruiz, Sen

A. REQUEST FOR LEGAL ACTION : ☐ **Summary Suspension** ☐ **Summary Action** ☐ Practice Restriction

☐ Statement of Charges	☐ Statement of Allegations /Stipulation to Informal Disposition
☐ Withdrawal of SOC	☐ SOA/STID for Voluntary Surrender
☐ Notice of Decision on Application: (Denied)	☐ Withdrawal of SOA
☐ Notice of Decision on Application (Granted with conditions)	☐ Notice of Correction

Alleged Violations—RCW 18.130.180:

☐ **(1)** Moral turpitude	☐ **(10)** Aiding and abetting	☐ **(19)** Treating by secret methods
☐ **(2)** Misrepresentation of facts	☐ **(11)** Violation of rules	☐ **(20)** Betrayal of patient privilege
☐ **(3)** False advertising	☐ **(12)** Practice beyond scope	☐ **(21)** Rebating
☐ **(4)** Incompetence	☐ **(13)** Misrepresentation or fraud	☐ **(22)** Interference with investigation
☐ **(5)** Out of state action	☐ **(14)** Failure to supervise	☐ **(23)** Current drug/alcohol misuse
☐ **(6)** Illegal use of drugs	☐ **(15)** Public health risk	☐ **(24)** Sexual contact/patient abuse
☐ **(7)** Violated state or federal law	☐ **(16)** Unnecessary or inefficacious drugs	☐ **(25)** Acceptance of more than nominal gratuity
☐ **(8)** Failure to cooperate	☐ **(17)** Criminal conviction	
☐ **(9)** Failure to comply	☐ **(18)** Criminal abortion	

Other Violations of Relevant State or Federal Law or RCW 18.130.170: _____
☐ Mental Impairment ☐ Physical Impairment

B. CLOSED AFTER INVESTIGATION:

☐ Application investigation only - Panel decides to grant without conditions	☐ A7-Mistaken identity
☐ A1-Care rendered was within standard of care	☐ A8-No jurisdiction
☐ A2-Complainant withdrew	☐ A11- No whistleblower
☐ A3- Unique closure (Panel must explain)	☐ A12-Risk minimal, not likely to reoccur
☒ A5-Evidence does not support a violation	☐ Sexual Misconduct : RCW 18.130.062 No standard of care MQAC retain / Refer to Secretary non clinical

OTHER EXPLANATIONS (Legal Review, Return to Investigation)
1)

2)

GUIDE FOR CLOSURE CODES
September 2011

Code	Closure	Description
	Application	Decision to grant an unrestricted license.
A-1	Care rendered was within standard of care	The evidence establishes that the respondent met or exceeded the standard of care.
A-2	Complainant withdrew complaint	The complainant withdrew the complaint, and the complainant's testimony is necessary to meet the burden of proof.
A-3	Unique closure (Panel must explain)	Any concerns regarding Respondent have been resolved through corrective action, license revocation, and suspension, death of respondent or other circumstances. • (explain): _____ _____ _____
A-5	Evidence does not support a violation	• The evidence is not sufficient to establish by clear, cogent, and convincing evidence that Respondent violated any UDA provision. • This includes situations in which the investigator was unable to obtain all material evidence.
A-7	Mistaken Identity	The case opened under the wrong respondent's name.
A-8	No Jurisdiction	Respondent is not licensed in Washington, has never been licensed in Washington, and is not applying for a license in Washington.
A-11	No Whistleblower Release	Complainant would not sign a whistleblower release AND the release of complainant's identity is necessary to prove a UDA violation.
A-12	Risk Minimal-Not likely to Reoccur	There is sufficient evidence that Respondent violated the UDA, but the evidence indicates that: (a) the violation is not likely to reoccur and (b) closure poses no more than a minimal risk to the public.

zdan guideclosecode revised mlf 0914-2011

Landreau, Teresa (DOH)

From: Landreau, Teresa (DOH)
Sent: Monday, January 09, 2012 7:34 AM
To: Clower, Athalia (DOHi)
Subject: RE: WKHarris 2011-157968 MD

Hi Athalia,
Since the consent agenda is closed this one will be presented to the panel for discussion, unless you need more info first. I don't have the clinical expertise to weigh in on standard of care, but am learning from you all. I'm guessing you didn't agree with complainant's allegations about failure to detect heart valve issue, failure to diagnosis hip implant issue, failure to address depression. What did you think about the failure to provide med records to the pt on request allegation? I guess that is one that would need follow-up, if you think its warranted. If the panel wants to open on the medication issues you raise, we should consider whether to send R a specific follow-up asking for his explanation on those narrower concerns.
See you Thursday. Thanks.
Teresa
(360) 236-2769

MQAC - Promoting Patient Safety and Enhancing the Integrity of the Profession through licencing, discipline, rule-making, and education

-----Original Message-----
From: raclower@pocketinet.com [mailto:raclower@pocketinet.com]
Sent: Saturday, January 07, 2012 7:42 PM
To: Landreau, Teresa (DOH)
Subject: WKHarris 2011-157968 MD

Hello.
Please see the attached notes on the chart review of this respondent.
Not enough to charge by all means, but enough to make one wonder if he is really providing adequate care.
Should we ask the panel?
Please let me know your thoughts. Thank you.

Landreau, Teresa (DOH)

From: raclower@pocketinet.com
Sent: Saturday, January 07, 2012 7:42 PM
To: Landreau, Teresa (DOH)
Subject: WKHarris 2011-157968 MD
Attachments: 2012-Commission-William K Harris-2011-157968.docx.html

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Not enough to charge by all means, but enough to make one wonder if he is really providing adequate care.
Should we ask the panel?
Please let me know your thoughts. Thank you.

Landreau, Teresa (DOH)

From: Landreau, Teresa (DOH)
Sent: Wednesday, January 04, 2012 2:51 PM
To: Clower, Athalia L (DOH)
Subject: case update for Jan 12 meeting
Attachments: Haining Robert MD tl AOModification.docx.html

Categories: Red Category

Hi Athalia,

Happy New Year!

Please review the attachment and let me know what you think of this proposed Modification Order for Dr. Haining. The additional restriction from providing non-emergent medical tx in residential care facilities between 9 pm & 6 am, and the requirement of a chaperone for female breast/genitalia exams, is at paragraph 4.2 on page 3 of 7.

The only other case we currently share is 2011-157968, which is a completed investigation for presentation. Below is the text of my summary from Nov 10 for this case:

Welcome back and see you next week.

2011-157968: This is Joy Johnson's completed investigation of the patient complainant's allegations that Respondent (R) provided substandard care for five years that:

1. failed to detect or prevent a heart valve problem,

2. 2failed to adequately diagnose hip implant issues,

3. failed to address her depression,

4. failed to inform of the risks of medication prescribed and

5. failed to provide the patient with her own medical records on request.

Respondent's letter (pp. 19 - 30) explains a delayed diagnosis with a detailed accounting of treatment, and includes medical records, including hip & knee X-rays. Respondent denies that the patient had reported marked chest pain or a history of angina to Respondent prior to her angiography with another doctor on 11/2/2010 (p. 25-26). Respondent doesn't address the alleged failure to provide the complainant with all of her medical records when requested - although this was included in the attachment sent with our letter requesting his explanation (p. 141).

The patient received a termination of care letter from respondent in late April 2011. Subsequent treatment by another physician diagnosed trochanteric bursitis caused by leg length discrepancy in May 2011 (p. 11) The patient filed her complaint in late June, 2011.

I'll be interested to hear your recommendation based upon your review of the medical records together with Respondent's explanation. Please let me know if I can assist. Thanks!

Teresa

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Landreau, Teresa (DOH)

To: Clower, Athalia L (DOH); 'Clower, Athalia'
Subject: Case update
Attachments: Haining Robert MD tl AOModification.docx.html; 2009-1178 executed AO.pdf.html

Hi Athalia,

Our only current completed investigation for presentation is 2011-157968, please see below.

On our one and only shared older matter, 2011-153352, please review the attached proposed modification for Dr. Haining and let me know if it meets your approval. The second attachment is the current order in effect on the earlier matters, for comparison.

Thanks and Happy New Year!

Teresa

(360) 236-2769

MQAC - Promoting Patient Safety and Enhancing the Integrity of the Profession

through licencing, discipline, rule-making, and education

From: Landreau, Teresa (DOH)
Sent: Thursday, November 10, 2011 4:00 PM
To: Clower, Athalia L (DOH); 'Clower, Athalia'
Subject: November case update

Hi Athalia,

I know you may be going to, have been, or currently are in Guatemala for what I hope will be a positive & memorable experience. On more mundane matters, we have only the following two cases that we are both currently assigned to:

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I'll be interested to hear your recommendation based upon your review of the medical records together with Respondent's explanation. Please let me know if I can assist. Thanks!

Teresa (360) 2336-2769

Teresa Landreau

Staff Attorney

Medical Quality Assurance Commission

243 Israel Rd SE, Olympia, WA 98501

P.O. Box 47866, Olympia, WA 98504-7866

Desk:(360) 236-2769

Fax: (360) 586-4573

MQAC -- Vigilant and dedicated to patient safety, the public's protection, and the integrity of the profession.

NOTE: This email exchange is a public record and may be subject to disclosure under Public Records Act, RCW 42.56

Landreau, Teresa (DOH)

From:	Hamilton, Cindy (DOH)
Sent:	Friday, July 08, 2011 3:26 PM
To:	Jansen, Maryella (DOH); Newman, Dani (DOH); Kramer, Mike (DOH); Heye, George (DOH); Smith, James H (DOH); Creighton, Vicki I (DOH); Bartley, Randy (DOH); Landreau, Teresa (DOH); Berg, Larry (DOH)
Cc:	Farrell, Michael (DOH)
Subject:	FW: You will call in for CMT -- Wednesday, July 13, 2011
Attachments:	CMT 07-13-2011 FULL PACKET Pgs 1-255.pdf.html; CMT--MQAC Policy&ProcedureStmt-MD2008-08-SEX-MISCON-Cases--1354_001 (2).pdf.html; CMT--MandatoryInvPolicyMD08-06--0593_001.pdf.html; CMT--ClosureCodes07-21-2010--1968_001.pdf.html

CMT is in room 523.

Following are the cases to be reviewed at CMT on Wednesday, July 6.

FULL PACKET

From: Hamilton, Cindy (DOH)
Sent: Friday, July 08, 2011 3:20 PM
To: Brantner, Richard (DOHi); Sen, Anjan (DOHi); Page, Judith (DOHi); Ruiz, Linda (DOHi)
Subject: You will call in for CMT -- Wednesday, July 13, 2011

Please email to let me know you have received the paper packet in the mail (if you were supposed to receive one) and this email directing you to call in to CMT.
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When we all connect for our CMT conference call on Wednesday, each of us will do so by calling in to our access phone number and then entering our meeting room number thereafter. Again, WE WILL NOT CALL YOU FOR CMT..YOU WILL CALL IN.

Remember, CMT starts at 9:00 am. By 9:00 am, please do the following to participate in the CMT conference call:

* Dial your access number: 1-877-351-4402
* Enter the conference code number: 2368560#
* The recording will prompt you to state your name, and you should be connected.
* Number to call: 1-877-351-4402
* Conference Code Number: 2368560#

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Friday, July 8, 2011

Richard Brantner MD
Anjan Sen MD
Judy Page JD, Public Member
Linda Ruiz JD, Public Member

Dear Commissioners:

Note: We may have add-ons, so be sure to check your email Tuesday afternoon/evening.

Following is a list of cases for review at CMT on Wednesday, July 13, beginning at 9:00 am. Unless otherwise noted, the complaint will appear only once after any two or more assessments

in companion case combos. The full packet contains an assessment followed by the complaint for each of the new cases. Please review the full packet (with complaints) prior to CMT.
NOTE: Due to the relatively small packet size, there is no assessments/reports-only packet this week. Your packet this week is 255 pages.
NEW Record for the largest packet: CMT 10-27-2010; Tobin, Concannon, Brantner and Gotthold; 685 pages.
CMT 06-15-2011; Harder, Brantner, Ruiz and Elders; 642 pages.
CMT 07-21-2010; Harder, Brantner, Ruiz and Page; 579 pages.
CMT 12-16-2009; Dore, Burger, Elders and Concannon; 558 pages.

I have posted the full packet in your respective accounts on the Secure File Transport site (https://sft.wa.gov/).
If you have any trouble logging on to the SFT site, please let me know asap.

Regarding paper copies:
Commissioner Brantner: Paper copy mailed to you.
Commissioner Sen: Paper copy mailed to you.
Commissioner Page: Paper copy mailed to you.
Commissioner Ruiz: No paper copy mailed to you.

**If you prefer to use the electronic version only, please let me know and I won't mail out a paper copy to you in the future.

(Unredacted) STIPULATION TO MODIFY AGREED ORDER / Page that case begins on. Approved by RCM Bruce Andison MD; presentation by Staff Atty Larry Berg.
M2008-118737 - Page 1
(Unredacted) New Assessments/Complaints / Page that case begins on:
2011-157883 - Page 7
2011-157911 and 2011-157912 - Page 13
2011-157919 and 2011-157920 - Page 25
2011-157968 - Page 33
2011-157972 and 2011-157972 - Page 40
2011-157986 - Page 46; and 2011-157989 - Page 50
2011-157991 - Page 54
2011-158001 - Page 61
2011-158012 - Page 63
2011-158013 - Page 69
2011-158014 - Page 73
2011-158018 - Page 77
2011-158019 - Page 83
2011-158021 - Page 88
2011-158022 - Page 94
2011-158024 - Page 99; and 2011-158026 - Page 210
2011-158032 - Page 213
2011-158035 - Page 218
2011-158038 - Page 224
2011-158045 and 2011-158046 - Page 230
2011-158047 - Page 242
2011-158055 and 2011-158056 - Page 245
(Redacted) Post-Investigation Reports / Page that case begins on:
2011-156094 - Page 250
2011-156673 - Page 251
2011-156843 - Page 252
2011-156875 - Page 253
2011-157176 - Page 254
2011-157319 - Page 255
Last page in the packet is 255.

SEXUAL MISCONDUCT CASES: *See MQAC Policy and Procedure Statement No. MD2008-08 - Referral of Sexual Misconduct Cases* (Below)
AFTER (1) authorizing the case for investigation; and (2) setting the case as a Priority A; you may make one of three decisions on a sexual misconduct case:

* Refer case to the Secretary of Health to act as the sole disciplining authority (sexual misconduct cases that DO NOT involve clinical expertise or standard of care issues) pursuant to RCW 18.130.062 (attached); or
* Retain case (sexual misconduct cases that DO involve clinical expertise or standard of care issues); or
* Authorize a brief investigation if you feel the complaint does not contain sufficient information to make one of the above decisions.

MQAC Policy and Procedure Statement No. MD2008-08 - Referral of Sexual Misconduct Cases:

Mandatory Investigations Policy No. MD 08-06:

Closure Codes: ****NOTE: This is a revised document (07-21-2010).. Please use this version when discussing closure codes.

Once CMT is over, you may dispose of your paper copy and delete the electronic files if you saved them on your computer.

~*
Cynthia R. Hamilton
Washington State Department of Health
Medical Quality Assurance Commission
PO Box 47866 (243 Israel Road SE); Olympia, WA 98504-7866
~*
Telephone: (360) 236-2762 Fax: (360) 236-2795
E-mail: cynthia.hamilton@doh.wa.gov
~*
MQAC webpage: http://www.doh.wa.gov/hsqa/professions/Medical/default.htm
Health Professions Provider Credential Search:
http://www.doh.wa.gov/hsqa/Professions/hpqalinks.htm

Landreau, Teresa (DOH)

From: Landreau, Teresa (DOH)
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close A-5

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CASE NO. 2011-157968 MD

WILLIAM K HARRIS, MD

Several issues with the care provided by this respondent:

1-Patient is being prescribed Indocin for arthritis and Prilosec for heartburn. Indocin is known to create gi upset and possible bleed.

2-Patient was rx'd Indocin (NSAID) see note of 10/4/10 page 76; her creatinine clearance of 9.21.2010 was 1.22 and two months prior was 1.57. She was also prescribed metformin. Both of these meds are contraindicated with kidney disease.

3-I do not see the notes where the assistant states the reason for the visit, or the vitals taken by assistant.

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CONFIDENTIAL INVESTIGATIVE REPORT

PREPARED FOR THE

MEDICAL QUALITY ASSURANCE COMMISSION

****

CASE #2011-157968MD

Respondent:

WILLIAM K HARRIS MD

1 - DOH Licensee Health Professional hom...

Attorney:

NONE PROVIDED

Specialty: FAMILY MEDICINE
Board Certification: FAMILY MEDICINE
Type of Practice: OFFICE BASED
DOB: 07-17-1963
Licenses: INITIAL: 05-27-1991; EXPIRATION: 07-17-2011
Medical School: 1988-Texas A&M U Sys HSC, Coll of Med; College Station, TX
Residency: 07/1988-06/1991-Texas Tech U Hlth Sci Ctr; TX
FAMILY MEDICINE

Complainant:

6 - Identity - Whistleblower and whistleblower's healthc...

Attorney:

NONE PROVIDED

Investigative Case File completed by Investigator: Joy Johnson, RN
Date: October 31, 2011

APPROVED: James A Smith DATE: 10-31-11

PRIOR CASE HISTORY:

1996-07-0042MD: Closed NCFA

2001-01-0024MD: The son contended that despite family concerns regarding the Respondent's prescribing of Valium to their father, who attempted suicide by overdosing on the medication and alcohol approximately 6-8 months ago, the Respondent has continued to prescribe. The Complainant contended their father has been depressed since the death of their mother and that he recently attempted suicide again. When the family allegedly reported their concerns to the Respondent, he replied that their father was a big boy and could take care of himself. ***Closed NCFA***

2002-01-0056MD: The Complainant advised that when a search warrant was executed at Cecil Smart's residence marijuana grow operation was found. Posted on the door to the grow room was an Authorization to Possess Marijuana for Medical Purposes in Washington State signed by the Respondent. The SO interviewed the Respondent and found that Mr. Smart was seen on one occasion on 8/16/01. The Authorization was for Smart's arthritic knees. The Respondent provided authorizations to three other patients. The three names are not supplied. ***Closed NCFA***

2008-124866: This complaint was from the custodial father of an 11y/o patient who was accompanied to the respondent's office by the mother. The complaint was difficult to understand but the Respondent appeared to have renewed the child's ADHD medication based on what the child said he was taking. It appeared the mother did not know the medication or the correct dosage and that the dosage prescribed was in fact incorrect. ***Closed NCFA***

2008-130652: The Complainant alleged she had been a patient of the Respondent for about ten years and that in September she received a letter from his office discharging her as a patient. The letter said he would provide emergency care for thirty days. The patient had been on high dose opioids and benzodiazepines for years and at the time of her discharge, she was on 20 different medications prescribed by the Respondent. She alleged she was unable to get an appointment to see him so she had to withdraw from the medications without his help. She said this caused her to end up in the ER at least four times for re-hydration and potassium supplementation. She felt the Respondent needlessly placed her health in jeopardy. ***Closed NCFA***

GENERAL CASE SUMMARY

COMPLAINT / ALLEGATIONS:

The Complainant/Patient, 6 - Identity - Whistleblo..., alleged that during the five years she received care from the Respondent, William K. Harris, MD, he mostly ignored her various symptoms and complaints, e.g., palpitations, shortness of breath, and dyspnea on exertion. The Respondent ordered an EKG which he told her "was good" but the Complainant wanted additional testing done so she self referred to a cardiologist who performed coronary angiography and diagnosed her with a valve problem. Five days later, she had open-heart surgery (not further

described). She also told the Respondent about a painful knee that made her suspect a problem with her hip implants. The Respondent dismissed this and told her she had arthritis. She self referred to an orthopedist who diagnosed her with a ½-inch leg length discrepancy. He prescribed a shoe lift that Complainant found helpful. The Complainant included a 4/26/2011 letter from the Respondent discharging her from his practice. She did not mention the letter in her complaint. Subsequently, the Complainant submitted an additional letter, copies of medical records, and a CD containing 05/06/11 hip and knee x-rays (Pg. 17). The Complainant was interviewed. (File: Pg. 2-18)

CASE REVIEW:

A statement (Pg. 19-30) and medical records (Pg. 31-122; Attachment A) were requested and received from the Respondent. NOTE: The Respondent's statement was comprehensive and the medical records were received with the plastic separations already in place; in addition, selected medical records were copied and placed within the Case file. (File: Pg. 19-122; Attachment A)

NOTE: The selected medical records contained vital sign sheets (Pg. 35-36) and medication logs (Pg. 31-33). In addition, the records indicated the Respondent did diagnose and attempted to treat the Complainant's diabetes. Attachment A contained medical records from a previous provider, physical therapy reports, and copies of prescriptions. (File: Pg 35-122; Attachment A)

On 06/28/06, the Complainant initially presented to the Respondent with complaints of SOB, dyspnea with exertion, and hip pain related to the 2001 & 2004 hip replacements; she uses a cane (Pg 13-16). The Complainant presented with a medical history of hypertension, hyperlipidemia, arthritis, and depression. A PE was performed and medications prescribed. Subsequent visits focused upon her depression and insomnia. (File: Pg. 13-16, 118)

On 01/15/07, the Complainant presented with complaints of palpations with associated dizziness. An ECG (atrial fibrillation with aberrant conduction and PVCs) was obtained and a wheelchair was prescribed per the Complainant's request. Digoxin was prescribed and labs ordered (no apparent report submitted). (File: Pg. 112-117)

On 02/13/07, the Complainant C/O palpations related to Digoxin, without dizziness and no SOB. On 04/03/07, the Complainant complained of knee and toe pain, dizziness, and nausea. A knee exam was performed and Indocin prescribed. An x-ray of the knee revealed "severe" DJD. A brain CT was inconclusive. On 05/10/07, the Complainant had no further episodes of irregular heartbeat. (File: Pg. 106-111)

On 03/07/08, Type 2 Diabetes was initially diagnosed. On 05/22/08, the Complainant C/O exacerbated bilateral hip pain radiating to her thighs following a Walmart scooter incident. Naprosyn was prescribed. On 08/27/08, carotid bruits were assessed by a PA-C. On 10/23/08, the Respondent apparently performed a cardiopulmonary exam that was "benign." A carotid ultrasound was ordered (no apparent report within the records). On 10/23/08, notation indicated the Complainant was still interested in pursuing evaluation of the carotid bruit. (File: Pg. 96-97, 101, 103)

On 02/09/09, the Complainant denied SOB, chest pain, racing heart, skipped beats, and palpitations. On 05/13/09 a cervical Spine MRI was ordered following C/O "pins-and needles" in her right arm and hand ("C5-6 central canal stenosis with myelopathy"). The Complainant was referred to a neurologist who assessed bilateral carotid bruits with stenosis and recommended a carotid Doppler or MRA. The Doppler revealed "bilateral... plaques without...significant degree of stenosis." (File: Pg. 85-94)

On 05/27/10, the Complainant C/O "mental deterioration...and has no ambition." Wellbutrin was prescribed. On 06/03/10, the Complainant complained of polyuria, polydipsia, blurry vision, and adhedonia. The apparent HEENT and cardiopulmonary exam were benign. On 07/10/10, the Complainant complained of "...fatigue and being unsteady on her feet." On 09/10/10, the Complainant presented to an urgent care facility with complaints of "dizziness and light-headedness." The Respondent saw the Complainant and discontinued the Atenolol; apparent HEENT and cardiopulmonary exams were benign. (File: Pg. 78-81)

On 09/21/10, the Complainant complained of continuing dizziness and lethargy. She stated, "...she had not felt well for a year." The Respondent stopped the Lisinopril and gave her a Lifeline application. On 10/04/10, the Complainant presented with "well localized sternal chest tightness with SOB, fatigue, and DOE." An office ECG was "benign." A "Room Air Pulse OX was 94%. The Complainant was referred to a cardiologist. (File: Pg. 71-77)

On 10/29/10, the Complainant was seen by the cardiologist who, based upon the resting ECG and the Lexican Myoview, assessed Class 3 angina and dyspnea. He wanted to R/O coronary artery disease, and recommended a right and left heart cath. Sublingual Nitroglycerin was prescribed. Providence St Peter (SPH) consult assessed "severe to critical aortic stenosis becoming increasingly progressive." On 11/10/10, an aortic valve replacement was performed at SPH. NOTE: On 11/04/10, the medical records contained a copy of a telephone note that indicated the Respondent spoke to the cardiologist reportedly, to find out if he could have done anything differently (Pg. 26, 60-61). (File: Pg. 25-26, 51-70)

Subsequently, the Complainant was seen by the Respondent on 01/05/11, 01/26/11, 02/28/11, 03/16/11, and 04/20/11 complaining of foot and knee pain; lab work and knee Imaging were obtained, and a referral to a podiatrist. Apparently, due to the Complainant's behavior (appeared the Complainant felt her hip rather than her knee should have been evaluated) she was terminated on 04/26/11. (File: Pg. 4, 37-50)

On 05/06/11, the Complainant was seen by an Orthopedist who diagnosed "... trochanteric bursitis Imparted by leg length discrepancy." X-rays were taken. A steroid Injection was administered and a shoe lift prescribed. On 09/19/11, reportedly the shoe lift was "not working well." (File: Pg. 10-11, 17-18)

CONTACTS:

NONE

ACTIVITY:

Date	Activity
06-29-11	Complaint received.
07-06-11	Initial Assessment Review: G. Heye, MD.
07-13-11	Investigation was received at the Medical Investigation Unit.
07-13-11	Investigation was assigned: J. Johnson, RN.
07-18-11	Acknowledgement and Whistleblower Waiver letters were sent to the Complainant.
07-18-11	Sent the Notification letter to the Respondent.
08-02-11	Sent the second Whistleblower Waiver letter to the Complainant.
08-03-11	Received the signed Whistleblower Waiver from the Complainant.
08-08-11	Investigation was received by J. Johnson, RN.
09-02-11	Case file reviewed and opened the Case Report.
09-02-11	Sent the Letter of Cooperation to the Respondent.
09-19-11	T/C (11:10 AM to the Complainant: I left the message requesting a return call should she have anything further to add to her

Complaint. I thanked her for the additional medical records and the CD of radiographs.

09-19-11 T/C (11:50 AM) to the Complainant: I left the message that I received notice from the Administrative Assistant that you had called; therefore, I was returning your call.

09-19-11 T/C (11:53 AM) from the Complainant: Complainant Interview: Memo to File.

09-19-11 Received the hand delivered statement and medical records via Nshea from the Respondent.

09-23-11 Received this date and apparently, hand delivered, the first page of the Respondent's statement.

09-26-11 Copied the selected pages from the medical record to include within the Case file; also paginated the binder of medical records from the Respondent.

09-28-11 Reviewed the Case file; began the Case Report.

10-06-11 Above entry, 09/28/11, was entered this date.

10-28-11 Reviewed the Case file; began and completed the Case Report.

10-31-11 Completed the final proof of the Case Report.

10-31-11 File submitted for Program Management review.

MQAC ASSIGNMENT MEMO

Case #: 2011-157968

Respondent: Harris, William K.

Date Received: 7-13-11 Date Assigned: 7-13-11

Investigator: Joy Johnson

Priority: A____ B____ C X D____ Code: 04

X Respondent Notification Letter

X Complainant Acknowledgement Letter

X Whistleblower Letter & Waiver

____ Malpractice Letter

Abandonment	Health & Safety Violations	Neglect	Possible Summary Action	Sexual Misconduct
Abduction	High visibility	No Patient Harm	Practice Beyond Scope	Single Complaint Process
Abuse	Imminent Harm	Non-Compliance	Prohibition in another state	Standard of Care X
Action w/other state/jurisdiction	Inappropriate Communication	Other	Sanitation	Substance Abuse
Credential Application	Inspection Issues	Patient Abuse	Serious Injury	Testing Issues
EMTALA	Jurisdictional Questions	Patient Death	Serious Physical Harm	Transfusion Fatality
Exposure to physical/fire hazards	Mandatory Suspension	Physical Plant	Sexual Contact	Unlicensed Practice

Comments: _____

Background Check Processed

JUL 14 2011

NPDB/HIPDB
DEPARTMENT OF HEALTH
MEDICAL COMMISSION

MQAC REVIEW
Case Number: 2011-157968

Date: July 6, 2011
Presented by: George Heye, MD

Respondent:	HARRIS, WILLIAM K., MD	Thurston County

Complainant:	Ms. 6 - Identity - Whistleblower an...

CASE SUMMARY

The Respondent:

Board Certified:	FAMILY MEDICINE
DOB:	07-17-1963
Licensed since:	05-27-1991
Expiration date:	07-17-2011
Medical School:	1988—Texas A & M U Sys HSC, Coll of Med; College Station, TX
Residency:	07/1988-06/1991—Texas Tech U Hlth Sci Ctr; TX—FAMILY MEDICINE

The Complainant: A patient

Malpractice Settlement:

The Complaint: The complainant writes that during the five years that she received care from the respondent he mostly ignored her various symptoms and complaints, e.g., palpitations, shortness of breath, dyspnea on exertion. Respondent ordered an EKG which he told her "was good" but the complainant wanted additional testing done so she self referred to a cardiologist who perfonmed coronary angiography and diagnosed her with a valve problem. Five days later she had open heart surgery (not further described). She also told the respondent about a painful knee which made her suspect a problem with her hip implants. Respondent dismissed this and told her she had arthritis. She self referred to an orthopedist who diagnosed her with a ½ inch leg length discrepancy. He prescribed a shoe lift which complainant found helpful.

The patient includes a 4/26/2011 letter from the respondent discharging her from his practice. She does nol mention the letter in her complaint.

RCM Review

Prior Cases:

93-07-0072MD Closed NCFA.

96-07-0042MD Closed NCFA.

01-01-0024MD The son contends that despite family concerns regarding the Respondent's prescribing of Valium lo their father, who attempted suicide by overdosing on the medication and alcohol approximately 6-8 months ago, the Respondent has continued to prescribe. The Complainant contends their father has been depressed since the death of their mother and that

he recently attempted suicide again. When the family allegedly reported their concerns to the Respondent he replied that their father was a big boy and could take care of himself.
Closed NCFA.

02-01-0056MD The complainant advises that when a search warrant was executed at Cecil Smart's residence a marijuana grow operation was found. Posted on the door to the grow room was an Authorization to Possess Marijuana for Medical Purposes in Washington State signed by the respondent. The SO interviewed the respondent and found that Mr. Smart was seen on one occasion on 8/16/01. The Authorization was for Smart's arthritic knees. The respondent has provided authorizations to three other patients. The three names are not supplied.
Closed NCFA.

2008-124866 This complaint is from the custodial father of an 11y/o patient who was accompanied to the respondent's office by the mother. The complaint is difficult to understand but the respondent seems to have renewed the child's ADHD medication based on what the child said he was taking. It appears that the mother did not know the medication or the correct dosage and that the dosage prescribed was in fact incorrect.
Closed NCFA.

2008-130652 – The complainant says that she has been a patient of the respondent for about ten years and in September she received a letter from his office discharging her as a patient. The letter said he would provide emergency care for thirty days. The patient has been on high dose opioids and benzodiazepines for years and at the time of her discharge she was on 20 different medications prescribed by the respondent. She says that she was unable to get an appointment to see him so she had to withdraw from the medications without his help. She said this caused her to end up in the ER at least four times for re-hydration and potassium supplementation. She feels that the respondent needlessly placed her health in jeopardy.
Closed NCFA.

Recommendation:

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
P.O. Box 10832
Chantilly, VA 20153-0832

http://www.npdb-hipdb.hrsa.gov

DCN: 3 - Healthcare Integrity and ...
Process Date: 07/14/2011
Page: 1 of 1
3 - Healthca...
For authorized use by:
WASHINGTON STATE DEPARTMENT OF HEALTH

QUERY RESPONSE

3 - Healthcare Integrity and Protection Data Bank information or National Practitioner Data Bank Information – RCW 42.56.510, 45 CFR 61.14

CONFIDENTIAL DOCUMENT - FOR AUTHORIZED USE ONLY

Medical Quality Assurance Commission

CMT

Review of Cases

CMT Date/
Panel Members/
Decision:

MQAC CMT - JULY 13, 2011
Richard Brantner, MD, Chair
Anjan Sen, MD
Judy Page, Public Member
Michael Concannon, JD, Public Member
DECISION: **Investigation authorized**

Case No.: - 2011 - 157968

The attached pages were reviewed:

033 - 039

MQAC REVIEW
Case Number: 2011-157968

Date: July 6, 2011
Presented by: **George Heye, MD**

Respondent:	HARRIS, WILLIAM K., MD	Thurston County

Complainant:	Ms. 6 - Identity - Whistleblower and...

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Closed NCFA.

Recommendation:

Washington State Department of Health

Medical Quality Assurance Commission
Intake Coordinator
PO Box 47866
Olympia, WA 98506-7866
Phone: 360.236.2762 Fax: 360.586.4573
E-mail: medical.commission@doh.wa.gov

RECEIVED
JUN 29 2011
DEPARTMENT OF HEALTH
MEDICAL COMMISSION

Complaint Form

Today's Date: 5/17/11

1. Your Information

Name: 6 - Identity - Whistleblower and whistleblower's healthcare information - RCW 42.56.510, RCW 43.70.0...

Address: 6 - Identity - Whistleblower and whistleblower's healthcare information - RCW 42.56.510, RCW 43.70.075, RCW 4...

City: 6 - Identity - Whistleblower and whistleblo... State 6 - Identity - Whi... Zip: 6 - Identity - Whistleblo...

Phone: Home: 6 - Identity - Whistleblower and whistleblo... Work: ( ) -

Cell Phone: ( ) SAME E-mail:

2. Information about the Physician (MD) or Physician Assistant

Name of Physician (MD) or Physician Assistant: DR KIRK HARRIS

Clinic or Facility: 6981 LITTLE ROCK RD

Address: 6981 LITTLE ROCK RD SW SUITE 101

City: TUMWATER State: WA Zip: 98512

3. Patient Information

Full name: 6 - Identity - Whistleblower and whistleblower's healthcare information - RCW 42.56.510, RC...

Date of Birth: 6 - Identity - Whistleblower and w...

Date of incident: ONGOING SINCE 2006

4. Scheduling problems or personality conflicts are usually not within the Commission's ability to take action.

5. Reports involving fee for fee disputes or insurance claims are only investigated if there appears to be fraud involved.

6. Please describe your complaint in the space below. Include the names, title and phone number of any witnesses that were involved in the complaint.

7. Please attach any supporting documentation or additional information you may have.

You may submit a complaint to the Medical Commission by mail, fax or email at:

Medical Quality Assurance Commission
Intake Coordinator
PO Box 47866
Olympia, WA 98506-7866
Fax: .360.586.4573

Please describe your complaint in the space below. Include names, titles and phone numbers of any witnesses. Please attach copies of documents to support your complaint. You may mail, email or fax this form to the Medical Quality Assurance Commission at the physical address, email address, or fax number above. NEGLECT OF MY HEART PROBLEM DIABETES PROBLEM, DEPRESSION ANY PROBLEMS I PUT TO THE DR HE SKIPPED OVER HE GAVE ME A PILL WHEN I JUST WENT TO the DR I Complained To him My family history of heart troubles and Surgeries My mother & father heart, two sisters and ways and 53 yrs old both with aneurisms 3 Sisters with Strokes all have high Blood pressure Angina and Strokes I have always been very concerned about my heart. I told the DR I was having a

Please include additional sheets as necessary.

W. Kirk Harris, M.D.
FAMILY MEDICINE

6981 Littlerock RD SW Suite 101
Tumwater, WA 98512
360-943-3633 Tel
360-528-4643 Fax

Termination of Care Letter

6 - Identity - Whistleblower and wh...

04/26/2011

Dear 6 - Identity - Whistlebl...,

I regret to inform you that as of today I will no longer be your primary physician. We feel that we are not able to meet your medical needs at this time. We will only attend to emergency needs for the next 30 days.

Please consult the local physician referral service, your county medical society, or the yellow pages of your telephone book as soon as possible so that you may find another physician who will assume responsibility for your care.

Sincerely,

Harris, MD

W. Kirk Harris, MD

I had an issue with heart palpitations for over four (4) years. I was continually concerned and voiced my concerns repeated to Dr. Harris at my medical appointments during this four-year period. Dr. Harris did not address or treat the palpitations issue. This issue progressed to the point where I was so out of breath that I could not walk more than 20 feet without becoming tired, listless, and out of breath. I suffered a severe loss of appetite and fell into depression. I voiced my concerns about these symptoms to Dr. Harris. He still did nothing to address or treat theses concerns. I requested a referral to a cardiologist. He told me that my symptoms were merely a matter of my old age.

Dr. Harris is the only doctor I have ever treated with that did not come into the room to ask me to sit down on the table so he could listen to my chest and lungs with a stethoscope and take my vital signs. I would estimate that my vitals were taken no more than five or six times during the four and one-half years I was his patient.

My prior experience was with my treating physician in California. My vital signs were taken at every office visit. Even if a nurse took my vitals, the Medical Doctor would re-take them.

After my repeated requests to Dr. Harris to refer me for an EKG, he reluctantly agreed in October, 2010. Dr. Harris reported to me that the EKG "was good". However, I insisted on him prescribing more tests for my heart.

I went to Providence St. Peter Hospital of my own accord. I was not referred by Dr. Harris. I was seen by Dr. Brennan. He put me through some stress tests and immediately scheduled an angioplasty. He told me that he thought I might have a blockage in the artery, but he was a little doubtful about that, because he thought it was something more. While I was having the angioplasty, Dr. Brennan told me that there was no problem with my artery, but he found a problem with my heart valve. He wanted to schedule open-heart surgery as soon as possible. Dr. Brennan asked me how long I had had these symptoms. When I told him, "Four and one-half years", he was taken aback. He then asked me if I had ever had a stroke, heart attack. When I answered, "no", he was quite surprised.

Dr. Brennan sent Dr. Quinton to consult with me the same afternoon. I had open-heart surgery five days later.

I believe I was lucky that with Dr. Brennen, I got a doctor that knew what he was doing. He also took me off of my Indomicen prescription that

ORIGINAL

Dr. Harris had been prescribing for me for four years. Dr. Brennan informed me that Indomicen is very bad for the kidneys. Dr. Harris paid no attention to this issue and never informed me of the risks of long term Indomicen use.

In early 2011, I asked Dr. Harris about the DePuy hip implant recall because I have bilateral hip implants and my right knee was becoming increasingly more painful. I also told Dr. Harris that my balance was off while I walk. I told him that I have to be very cautions that I did not understand the cause of my poor balance issue. Dr. Harris repeatedly put me off in regards to making any recommendations for treatment. I knew my knee pain was the result of a problem with my hip implant and every time I brought up the balance issue and the knee pain to Dr. Harris, he ignored me! After repeatedly requesting an MRI of my hip, he sent me for an X-ray of my knee and told me that I had arthritis of the knee and gave me a prescription for Ocycodone. Dr. Harris much preferred to prescribe pain pills instead of addressing a problem. I asked for a referral to an Orthopaedist, but Dr. Harris ignored me again.

I self-referred myself to Dr. Brodie Wood at Olympia Orthopaedics. Dr. Wood X-rayed both hips and my knees. He discovered that my left hip replacement was not aligned properly with my prior right hip replacement, which resulted in my left leg being one-half inch shorter than my right leg. Dr. Wood prescribed a lift for my left shoe. I am already seeing improvement in my knee pain.

It is very sand when a patient sees the same doctor for almost five years and is treated with such disregard. I have experienced extreme patient neglect from Dr. Harris. I request that he be investigated and reprimanded for his improper and lack of adequate patient care. I also request that his license to practice medicine be tagged for incompetence. He is more interested in prescribing pain pills than he is in treating his patients.

Case View Screen [update]

Case	2011-157968 (PUBLIC)
Status	Intake
Respondent ID	293200
Respondent	WILLIAM K HARRIS
Credential	MD.MD.00028579
Complainant ID	997747
Complainant	6 - Identity - Whistleb...

Date Created	07/06/2011
Date Received	06/29/2011
How Received	Mail
Receiving Board	COMMISSION
Receiving Profession	Physician And Surgeon License
Receiving Department	Case Intake
Received By	Cynthia R Hamilton

Alleged Issues
Failure to Provide Medically Reasonable and/or Necessary Items or Services
Incompetence
Negligence
Patient Care
Patient Neglect

Case Nature
Standard of Care/Services

Audit
Entry Items
Documents
Notes
Master Cases
Participants
Add Master Case
Timeline History

Comments:

- **Priority History**
- **Other Participants**
- **Resolution**
- **HIPDB Reports**
- **Action Items**

Priority History [add]

Date	Priority	Priority Reason	Decision Maker	Decision Date	Comment	COR	User

Other Participants [add]

No additional participants found

Resolution [update]

Department: Case Intake
Worker: Cynthia R Hamilton
Date Closed:

Found Issues
none
Resolution
none

Resolution Notes:

Current HIPDB Reports

Type	Submission Date	Status	DCN	Case ID

No HIPDB Reports found for this credential.

Action Items [add] [add group]

Type	Assigned To	Activity	Due	Effective	Completed	Order Signed	Created ▼	User
Intake	Case Intake, Hamilton, Cynthia R			07/06/2011	07/06/2011		07/06/2011	Hamilton, Cynthia R
Target:	WILLIAM K HARRIS							
Warning:	Warning Type:	CASE PENDING						
	Warning Effective Date:	07/06/2011						
	Suppress License Print:	NO						
	Warning:	2011-157968						
Case Status:	Status Changed To:	Intake						
Action Info:	Complaint Source	Patient/Client/Resident						
	Possible Imminent Danger?	No						
	Single Compiaint Process Coordination Needed?	No						

AMA
AMERICAN
MEDICAL
ASSOCIATION

AMA Physician Profile

Name and Mailing Address:

W KIRK HARRIS MD
STE 101
6981 LITTLEROCK RD SW
TUMWATER WA 98512-7226

Primary Office Address:

SAME AS MAILING ADDRESS

Phone: 1-360-943-3633

Birthdate: 07/17/1963
Birthplace: LAON FRANCE

Physician's Major Professional Activity: OFFICE BASED PRACTICE

Practice Specialties Self Designated by the Physician*:

Primary Specialty: FAMILY MEDICINE

Secondary Specialty: UNSPECIFIED

"Self-Designated Practice Specialties/Areas of Practice (SDPS) listed on the AMA Physician Profile do not imply "recognition" or "endorsement" of any field of medical practice by the Association, nor does it imply, certification by a Member Medical Specialty Board of the American Board of Medical Specialties, or that the physician has been trained or has special competence to practice the SDPS.

AMA membership: MEMBER

All Information from this Point Forward is Provided by the Primary Source

Current and/or Historical Medical School:

TX A & M UNIV SYS HSC, COLL OF MED, COLLEGE STATION TX 77843

Degree Awarded: Yes

Degree Year: 1988

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AMA AMERICAN MEDICAL ASSOCIATION

AMA Physician Profile

Current and/or Historical Post Graduate Medical Training Programs Accredited by the Accreditation Council for Graduate Medical Education (ACGME):

Future training dates, as reported by the program, should be interpreted as "in progress" or "current" with projected date of completion. If the training program indicates that training for a physician in a particular specialty was not completed at their institution, the training segment will be identified as "INCOMPLETE TRAINING".

Institution: TX TECH UNIV HLTH SCI CTR — **State:** TEXAS
Specialty : FAMILY MEDICINE — 07/1988 - 06/1991 (VERIFIED)

Note: If you have discrepant information, please submit a Request for Investigation to the AMA so that we may verify the information with the primary source(s). See the last page of this Profile for instructions on how to report a data discrepancy.

Current and/or Historical Medical Licensure:

Jurisdiction	MD/ DO	Date Granted	Expiration Date	Status	License Type	Last Reported
OREGON	MD	10/24/1996	12/31/1999	INACTIVE	UNLIMITED	08/19/2003
WASHINGTON	MD	05/27/1991	07/17/2011	ACTIVE	UNLIMITED	06/20/2011
TEXAS	MD	12/06/1989	11/30/1994	INACTIVE	UNLIMITED	06/20/2011

Note: When the specific month and day are unknown, the date will display the default value of "01." Not all licensing boards maintain or provide full date values. Please contact the appropriate licensing board directly for this information.

Current and/or Historical NPI Information:

NPI Number	Enumeration Date	Deactivation Date	Reactivation Date	Replacement Number	Last Reported Date
1588662068	07/08/2005	03/15/2006	03/29/2006	NOT RPTD	06/03/2011

ECFMG Certfication:

Applicant Number:

Note: The Educational Commission for Foreign Medical Graduates (ECFMG) applicant identification number does not imply current ECFMG certification status. To verify ECFMG status, contact the ECFMG Certification Verification Service in writing at P.O. Box 13679, Philadelphia, PA 19101.

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AMA AMERICAN MEDICAL ASSOCIATION

AMA Physician Profile

Federal Drug Enforcement Administration:

* *Only the last three characters of active DEA number(s) are displayed.*

DEA Number *	Schedule	Expiration Date	Last Reported
XXXXXX829	22N 33N 4 5	10/31/2013	06/13/2011

Address: 6981 Littlerock Rd SW Ste 101, Tumwater, WA 98512-7226

Note: **Many states require their own controlled substances registration/license. Please check with your state licensing authority for requirement information as the AMA does not maintain this information.**

Specialty Board Certification(s)*:

Specialty Board Certification(s) by one or more of the 24 boards recognized by the American Board of Medical Specialties (ABMS) and the American Medical Association (AMA) through the Liaison Committee on Specialty Boards, as reported by the ABMS:

The AMA Physician Profile has been designated by the ABMS as an Official ABMS Display Agent of Member Board Certification data. Therefore, the ABMS Board Certification information on the AMA Physician Profile is considered a designated equivalent source in regard to credentialing standards set forth by accrediting bodies such as the Joint Commission and National Committee for Quality Assurance (NCQA).

Certifying Board: AMERICAN BOARD OF FAMILY MEDICINE
Certificate: FAMILY MEDICINE
Certificate Type: GENERAL

Duration	Effective	Expiration	Reverification	Occurrence	Last Reported
TIME LIMITED	07/16/2004	12/31/2014		RE-CERT	06/09/2011
TIME LIMITED	07/11/1997	12/31/2004		RE-CERT(**)	06/09/2011
TIME LIMITED	07/12/1991	12/31/1998		INITIAL(**)	06/09/2011

Note: **For certification dates, a default value of "01" appears in the day or month field if data were not provided to AMA. Please contact the appropriate specialty board directly for this information. (**) Indicates an expired certificate.**

***This information is proprietary data maintained in a copyrighted database compilation owned by the American Board of Medical Specialties. Copyright 2011 American Board of Medical Specialties. All right reserved.**

Medicare/Medicaid Sanction(s):

TO DATE, THERE HAVE BEEN NO SUCH SANCTIONS REPORTED TO THE AMA BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

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AMA AMERICAN MEDICAL ASSOCIATION

AMA Physician Profile

Other Federal Sanction(s):

TO DATE, THERE HAVE BEEN NO FEDERAL SANCTIONS REPORTED TO THE AMA BY ANY BRANCH OF THE US MILITARY, THE VETERAN'S ADMINSTRATION OR THE US PUBLIC HEALTH SERVICE.

Additional Information:

TO DATE, THERE IS NO ADDITIONAL INFORMATION FOR THIS PHYSICIAN ON FILE.

The content of the AMA Physician Profile is intended to assist with credentialing. Appropriate use of the AMA Physician Masterfile data contained on this Profile by an organization would meet the primary source verification requirements of the Joint Commission and the American Accreditation HealthCare Commission/URAC. The Physician Masterfile meets the National Committee for Quality Assurance (NCQA) standards for verification of medical education, post graduate medical training, board certification, DEA status, and Medicare/Medicaid sanctions.

If you note any discrepancies, please log onto our web site (http://www.ama-assn.org/go/amaprofiles) and go to the order detail page, select the D following the physician's name and enter the data in question. Or you can mark the issues on a copy of the profile and mail or fax to:

Division of Database Products and Licensing
Attn: Credentialing Products
515 N. State Street
Chicago, IL 60654
800- 665-2882
312 464-5900 (fax)

If you have questions or need additional information, please call the AMA Profile Service customer support line at 800-665-2882.

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Credential View Screen

WILLIAM K HARRIS
Address:

○ Public Mail Renewal Mail

[change public address]
WILLIAM K HARRIS
6981 LITTLEROCK RD SUITE 101
TUMWATER, WA 98501

ID	293200
Warnings	
SSN/FEIN	2 - DOH Licen...
Contact Standing	Living
Contact Type	INDIVIDUAL
Birth Date	07/17/1963
Public File	YES
Mailing List	
Legacy Licensure Name	HARRIS, WILLIAM K

Contact
Audit
Public Cases
Cont. Edu
Documents
Owned By/Key Mgmt
Exams
Experience
Notes
Schools
Supervises
SupervisedBy
Legacy
Librarian
Application
Other State License

2008-130652
NCFA

Comments: 060904 A/C SLT/

Physician And Surgeon License [form letter]

Credential #	MD.MD.00028579	**Credential Status**	**ACTIVE IN RENEWAL** (05/16/2011)
Legacy License #	MD00028579	Status Reason	RENEWAL NOTICE SENT
Application Date		**Amount Due**	**$0.00**
Effective Date	**06/09/2009**	Date Last Activity	1/5/2011 9:45:37 AM
Expiration Date	**07/17/2011**	Last Updated by	Mihelich, Joe D
First Issuance Date	05/27/1991	Certificate Sent Date	06/09/2009
Last Date Of Contact		Work Queue	LEGACYDATA, DOH
CE Due Date	07/17/2013		

Audit
Documents
Workflow
Key Mgmt
Fees
Notes
Print Docs
Comp. Audit
Renewal
Legacy

Comments: 060904 A/C SLT/

Supervises | User Defined License Data | Legacy | HIPDB

[update]

Contact Name	Credential	Credential Definition	Board	Supervision Type	Status
BRAD L GOLDWORM	**PA.PA.10004755**	PA-Physician Assistant License	COMMISSION	Physician Assistant Sponsorship	ACTIVE
TERESA ANN STOUFFER	**HCA.HC.00009284**	HCA-Health Care Assistant Certification	SECRETARY	Health Care Assistant Delegator	ACTIVE

2011-157968

Complainant View for 2011-157968 [back]

6 - Identity - Whistleb...

[change address]

6 - Identity - Whistleblower and ...

ID	997747
Contact Standing	Living
DOB:	
Phone #	
SSN/FEIN	
Public File	YES
Mailing List	
Contact Type	ENFORCEMENT ENTRY

6 - Identity - Whis...

Comments:

Credentials

Credential	Sub	License Type	License Issue	Expiration Date	Status	Reason

No Credentials on File

Update Contact | Change Contact

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION
PO Box 47866, Olympia, WA 98504-7866

January 30, 2012

William K. Harris, MD
6981 Little Rock Rd
Suite 101
Tumwater, WA 98501

RE: William K. Harris, MD
Case No. 2011-157968 MD00028579

Dear Dr. Harris:

The Medical Quality Assurance Commission has completed its investigation. The Commission is committed to protecting the health and safety of the citizens of the state of Washington. The Commission takes every complaint seriously.

To take disciplinary action against a physician's license, the Commission is required to prove by clear and convincing evidence that the physician's conduct violated the law. After careful review of the information gathered during the investigation, the Commission determined that the evidence does not support a violation. Based on this review, the Commission closed the case.

Washington State law provides you with the right to submit an additional written statement if you wish. Any statement you provide will be added to the investigative file. The investigative file is subject to public release pursuant to the Washington State Public Records Act.

The Washington State Public Records Act also provides you with the right to request copies of documents from the investigative file. If you would like a copy of the investigative report, or copies of documents gathered during the investigation, please submit a request to the Department of Health, Public Disclosure Unit, PO Box 47865, Olympia, WA 98504-7865 or fax your request to 360-586-2171.

The Commission thanks you for your cooperation during this investigation. The Commission understands that being investigated in disconcerting and inconvenient. Many physicians use this experience to initiate a self-critique of their practice and, when indicated, modify or improve certain areas of a practice. Thank you again for your cooperation in this matter.

Respectfully,

Dani Newman, Disciplinary Manager
Medical Quality Assurance Commission

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION
PO Box 47866, Olympia, WA 98504-7866

January 30, 2012

6 - Identity - Whistleblower and whistleblow...

Subject: William K. Harris, MD
RE: Case No. 2011-157968 MD00028579

Dear Ms. 6 - Identit...:

The Medical Quality Assurance Commission has completed its investigation concerning William K. Harris, MD. The Commission is committed to protecting the health and safety of citizens of the State of Washington. The Commission takes every complaint seriously.

To take disciplinary action against a physician's license, the Commission is required to prove by clear and convincing evidence, a high burden of proof, that the physician's conduct violated the law. After careful review of the information gathered during the investigation, the Commission determined that the evidence does not support a violation Based on this review, the Commission closed the case.

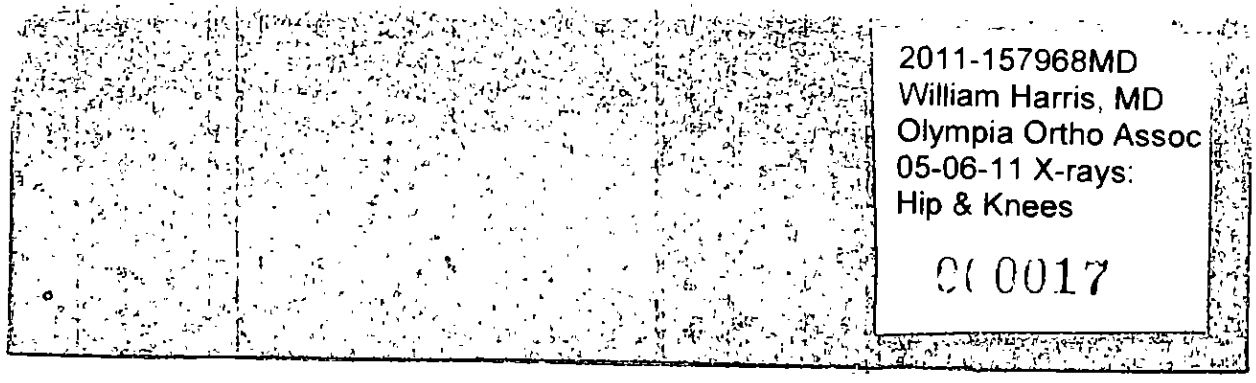
You may request reconsideration within thirty days of receiving this letter by submitting new information to the address below. The subject of the investigation by law will be notified of any new information submitted and given a chance to respond.

Thank you for bringing your concerns to the attention of the Medical Quality Assurance Commission.

Sincerely,

Melissa McEachron, Program Administrator
Medical Quality Assurance Commission
PO Box 47866, Olympia, WA 98504-7866


Radiology CD
DOB:
6 - Identity - W...
6 - Ide...
2011-157968MD
William Harris, MD
Olympia Ortho Assoc
05-06-11 X-rays:
Hip & Knees
OLYMPIA
ORTHOPAEDIC
ASSOCIATES, P.L.L.C.
www.olyortho.com


2011-157968MD
William Harris, MD
Olympia Ortho Assoc
05-06-11 X-rays:
Hip & Knees
C(0017

EVIDENCE / ATTACHMENTS:

Page	Description
01	WAC 246-15-030 notice
02-06	Received, 06/29/11, the Complaint letter.
07-17	Received, 08/11/11 from the Complainant, an additional letter, copies of medical records, and a **CD** containing hip and knee x-rays (05/06/11).
18	Conducted, 09/19/11, the Complainant interview.
19-30	Received, 09/19/11, the requested statement from the Respondent.
31-122	Received 09/19/11 and subsequently selected copies of the medical records from the Respondent.
*****	
123-125	Sent, 07/18/11, the DOH Acknowledgement and Whistleblower Waiver letters to the Complainant.
126-127	Sent, 08/02/11, the second Whistleblower Waiver letter to the Complainant.
128	Received 08/02/11, a telephone call from the Complainant via CI/JS.
129	Received, 08/03/11, the signed Whistleblower Waiver from the Complainant.
130	Received, 08/11/11, the signed Whistleblower Waiver from the Complainant.
131	Sent, 07/18/11, the Notification letter to the Respondent.
132-141	Sent, 09/02/11, the Letter of Cooperation to the Respondent.

ATTACHMENT:

A. Medical records for 6 - Identity - Whistleblower and... from William K. Harris, MD (Pages: 01-235).

NOTICE

WAC 246-15-030, procedures for filing, investigation, and resolution of whistleblower complaints.

(1)(b) Instructs that staff will affix a permanent cover to the letter of complaint or other form of notice in the complaint file, noting the statutory citation concerning protecting the identity of the complainant.

(3)(c) Ensure upon case closure, that the permanent cover affixed in subsection (1)(c) of this section will remain.

RCW 43.70 provides that the identity of a whistleblower who complains in good faith to the Department of health about the improper quality of care by a health care provider as defined in RCW 43.72.010 ***shall remain confidential***.

Pursuant to the above RCW and WAC it is staff's duty to see that the complainant's name or any information which may identify the complainant is not disclosed.

NOTICE

Washington State Department of Health
Medical Quality Assurance Commission
Intake Coordinator
PO Box 47866
Olympia, WA 98506-7866
Phone: 360.236.2762 Fax: 360.586.4573
E-mail: medical.commission@doh.wa.gov

RECEIVED
JUN 29 2011
DEPARTMENT OF HEALTH
MEDICAL COMMISSION

Complaint Form

Today's Date: 5/17/11

1. Your Information

Name: 6 - Identity - Whistleblower and whistleblower's healthcare information - RCW 42.56.510, RC...

Address: 6 - Identity - Whistleblower and whistleblower's healthcare information - RCW 42.56.510, RCW 43.70.075, RC...

City: 6 - Identity - Whistleblower and whistleblo... State: 6 - Identity - W... Zip 6 - Identity - Whistleblo...

Phone: Home: 6 - Identity - Whistleblower and whistleblo... Work: ( ) -

Cell Phone: ( ) SAME E-mail: /

2. Information about the Physician (MD) or Physician Assistant

Name of Physician (MD) or Physician Assistant: DR KIRK HARRIS

Clinic or Facility: 6981 LITTLE ROCK RD.

Address: 6981 LITTLE ROCK RD SW. SUITE 101

City: TUMWATER State: WA Zip: 98512

3. Patient Information

Full name: 4 - Healthcare information readily identifiable to a person - RCW 42.56.360(2) and RCW 70....

Date of Birth: 4 - Healthcare information readily ...

Date of incident: ONGOING SINCE 2006

4. Scheduling problems or personality conflicts are usually not within the Commission's ability to take action.

5. Reports involving fee for fee disputes or insurance claims are only investigated if there appears to be fraud involved.

6. Please describe your complaint in the space below. Include the names, title and phone number of any witnesses that were involved in the complaint.

7. Please attach any supporting documentation or additional information you may have.

You may submit a complaint to the Medical Commission by mail, fax or email at:

Medical Quality Assurance Commission
Intake Coordinator
PO Box 47866
Olympia, WA 98506-7866
Fax: .360.586.4573

Please describe your complaint in the space below. Include names, titles and phone numbers of any witnesses. Please attach copies of documents to support your complaint. You may mail, email or fax this form to the Medical Quality Assurance Commission at the physical address, email address, or fax number above. NEGLECT OF MY HEART PROBLEM DIABETES PROBLEM, DEPRESSION ANY PROBLEMS I PUT TO THE DR HE SKIPPED OVER HE GAVE ME A PILL. WHEN I JUST WENT TO the DR I explained to him my family history of heart trouble and aneurisms my mother & father heart, two sisters and uncle and 53yrs old both with aneurisms 3 sisters with strokes all have high blood pressure angina and strokes I have always been very concerned about my heart. I told the DR I was having a

Please include additional sheets as necessary.

W. Kirk Harris, M.D.
FAMILY MEDICINE

6981 Littlerock RD SW Suite 101
Tumwater, WA 98512
360-943-3633 Tel
360-528-4643 Fax

Termination of Care Letter

4 - Healthcare information readily id...

04/26/2011

Dear 4 - Healthcare inform...,

I regret to inform you that as of today I will no longer be your primary physician. We feel that we are not able to meet your medical needs at this time. We will only attend to emergency needs for the next 30 days.

Please consult the local physician referral service, your county medical society, or the yellow pages of your telephone book as soon as possible so that you may find another physician who will assume responsibility for your care.

Sincerely,

Harris, MD

W. Kirk Harris, MD

000004

4 - Healthcare informati... Statement re: Medical Complaint of Dr. Kirk Harris, MD

I had an issue with heart palpitations for over four (4) years. I was continually concerned and voiced my concerns repeated to Dr. Harris at my medical appointments during this four-year period. Dr. Harris did not address or treat the palpitations issue. This issue progressed to the point where I was so out of breath that I could not walk more than 20 feet without becoming tired, listless, and out of breath. I suffered a severe loss of appetite and fell into depression. I voiced my concerns about these symptoms to Dr. Harris. He still did nothing to address or treat theses concerns. I requested a referral to a cardiologist. He told me that my symptoms were merely a matter of my old age.

Dr. Harris is the only doctor I have ever treated with that did not come into the room to ask me to sit down on the table so he could listen to my chest and lungs with a stethoscope and take my vital signs. I would estimate that my vitals were taken no more than five or six times during the four and one-half years I was his patient.

My prior experience was with my treating physician in California. My vital signs were taken at every office visit. Even if a nurse took my vitals, the Medical Doctor would re-take them.

After my repeated requests to Dr. Harris to refer me for an EKG, he reluctantly agreed in October, 2010. Dr. Harris reported to me that the EKG "was good". However, I insisted on him prescribing more tests for my heart.

I went to Providence St. Peter Hospital of my own accord. I was not referred by Dr. Harris. I was seen by Dr. Brennan. He put me through some stress tests and immediately scheduled an angioplasty. He told me that he thought I might have a blockage in the artery, but he was a little doubtful about that, because he thought it was something more. While I was having the angioplasty, Dr. Brennan told me that there was no problem with my artery, but he found a problem with my heart valve. He wanted to schedule open-heart surgery as soon as possible. Dr. Brennan asked me how long I had had these symptoms. When I told him, "Four and one-half years", he was taken aback. He then asked me if I had ever had a stroke, heart attack. When I answered, "no", he was quite surprised.

Dr. Brennan sent Dr. Quinton to consult with me the same afternoon. I had open-heart surgery five days later.

I believe I was lucky that with Dr. Brennen, I got a doctor that knew what he was doing. He also took me off of my Indomicen prescription that

000005

ORIGIN

Dr. Harris had been prescribing for me for four years. Dr. Brennan informed me that Indomicen is very bad for the kidneys. Dr. Harris paid no attention to this issue and never informed me of the risks of long term Indomicen use.

In early 2011, I asked Dr. Harris about the DePuy hip implant recall because I have bilateral hip implants and my right knee was becoming increasingly more painful. I also told Dr. Harris that my balance was off while I walk. I told him that I have to be very cautions that I did not understand the cause of my poor balance issue. Dr. Harris repeatedly put me off in regards to making any recommendations for treatment. I knew my knee pain was the result of a problem with my hip implant and every time I brought up the balance issue and the knee pain to Dr. Harris, he ignored me! After repeatedly requesting an MRI of my hip, he sent me for an X-ray of my knee and told me that I had arthritis of the knee and gave me a prescription for Ocycodone. Dr. Harris much preferred to prescribe pain pills instead of addressing a problem. I asked for a referral to an Orthopaedist, but Dr. Harris ignored me again.

I self-referred myself to Dr. Brodie Wood at Olympia Orthopaedics. Dr. Wood X-rayed both hips and my knees. He discovered that my left hip replacement was not aligned properly with my prior right hip replacement, which resulted in my left leg being one-half inch shorter than my right leg. Dr. Wood prescribed a lift for my left shoe. I am already seeing improvement in my knee pain.

It is very sand when a patient sees the same doctor for almost five years and is treated with such disregard. I have experienced extreme patient neglect from Dr. Harris. I request that he be investigated and reprimanded for his improper and lack of adequate patient care. I also request that his license to practice medicine be tagged for incompetence. He is more interested in prescribing pain pills than he is in treating his patients.

July 10, 2011

State of Washington
Department of Health
Medical Quality Assurance Commission
P.O. Box 47866
Olympia, WA 98504-7866

RECEIVED
AUG 11 2011
DEPARTMENT OF HEALTH
MEDICAL COMMISSION

Re: William K. Harris, MD
Case No: 2011-157968MD

This will acknowledge and thank you for the recent letter informing me that my complaint is being investigated. Thank you for appreciating the seriousness of my concerns.

Please consider this response my supplementation of additional information pertaining to my complaint.

On February 16, 2010, I had an appointment with Dr. Harris regarding my ongoing hip and leg pain. The hip pain had become progressively worse over the past four years. I had previously expressed to Dr. Harris, at many, many prior appointments, my worry over this worsening hip pain. I have had two hip replacement surgeries, both at Vacca Valley Inter Community Hospital in Fairfield, CA, in the 1990's. Over the past approximately 4 years, I have developed an imbalance with walking; it as an instability in my step, causing me great worry that I may fall. As such, I have become very cautions about walking and this has greatly hindered my normal activities. The pain has been manifesting so long in my hip that my Left knee began hurting approximately two years ago. I have scheduled many appointments with Dr. Harris to discuss the knee and hip pain. He refused to refer me for any diagnostics, or to a specialist for other care. I asked for a referral to an orthopaedist. His answer was to prescribe me pain medication that I did not want and was afraid to take.

Last August, shortly after I learned of the DePuy hip recall, I again asked Dr. Harris to request copies of my hip replacement surgery reports so we could learn which hip implants I have. I asked again at my 02/16/2011 appointment with Dr. Harris. He reluctantly referred me for an X-ray. I thought I was being referred for hip X-rays, since the hips have been the most painful. He ordered a knee X-ray!

By February 25, 2011, I had not heard back from Dr. Harris's office regarding my request for the hip implant surgery reports. I called Vacca Valley Inter Community Hospital and spoke with the Records Department. They explained to me that they could not release the records to

HIP/UPPER LEG HISTORY FORM

Patient Name [redacted] Acct. #: 230162

RIGHT LEFT BOTH

1. Who referred you here for this problem? MYSELF

2. What is the nature of your hip problem (be as specific as you can)? HAD A HIP REPLACEMENT Right hip OCT 2001 LEFT HIP JAN 2004

3. How long have you had this problem? 4 WEEKS

4. Was there a specific injury? (NO) **YES** If Yes:

How did the injury occur? _____

When did the injury occur? _____ Where did the injury occur? HOME WORK SPORTS AUTO

5. Is your problem work-related? (NO) **YES** If yes, has a Workers' Compensation/L&I claim been filed? **YES NO**

Are you still working? **NO YES** If yes, Light Duty or Regular Duty? Full or Part Time?
If not working, last day of work _____

6. Current Symptoms:
Pain? **NO** (YES) If yes, Location LEFT KNEE + HIP

Severity 1 2 3 4 5 6 7 8 (9) 10 (circle a number)
Mild Moderate Severe

Circle what aggravates the pain:
Sitting Putting on Socks & Shoes (Walking/Standing) (Stairs) (Squatting/Kneeling) (Pivoting/Twisting)

What relieves the pain? _____

Do you have: (Pain at night) Numbness in legs Weakness in legs Catching or grinding sensations
Locking sensations (Stiffness)

7. What treatment have you tried? Ice Heat Crutches (Cane) Walker (Home Exercises) (Physical therapy)
Other _____ Anti-inflammatories (which ones) _____

8. Have you had x-rays? **NO** (YES) (where _____ When _____)

Have you had other studies (CT scan, MRI, bone scan, etc.) **NO** (YES)
What _____ Where VACAVILLE CA When SINCE 2000

9. What activities do you regularly participate in? CARDIO VASCULAR

Are you still able to participate in these? **NO** (YES)

Revised 6/10

OCC010

230162
4 - Healthcare information re...
DOB: 4 - Healthcare infor...
DOS: 05/06/2011
P. BRODIE WOOD, M.D.

DIAGNOSIS: Status post bilateral total hip arthroplasty with left trochanteric bursitis due to leg length inequality.

HISTORY OF PRESENT ILLNESS: 4 - Hea... is a delightful 75-year-old Scottish woman who presents self-referred for evaluation of her left hip pain, which has been present for four weeks in increasing severity, now rating 9/10, exacerbated by walking, standing, stairs, squatting, kneeling, pivoting, and twisting; associated with pain at night, stiffness. She has tried cane, home exercises, and physical therapy. She enjoys cardio and has difficulty performing this owing to hip pain.

MEDICATIONS: Aspirin, potassium, and metformin doses unknown.
PAST MEDICAL HISTORY: Notable for hypertension, diabetes, arthritis, and TB.
PAST SURGICAL HISTORY: Bilateral hip replacements and open heart surgery.
SOCIAL HISTORY: She is nonsmoker, utilizes no alcohol.
FAMILY HISTORY: Heart disease.
REVIEW OF SYSTEMS: Notable for visual impairment requiring glasses, depression, hearing loss, diabetes, joint stiffness, and anemia.

PHYSICAL EXAM: Demonstrates a 75-year-old woman standing 5'4", weighing 203 pounds. She is right-hand dominant, alert and oriented, and in no apparent discomfort. Blood pressure is 167/97, pulse 81, and nonlabored breathing. Pupils are equal, round, and reactive. Extraocular movements are intact. She has supple back, hip, knee, ankle, and subtalar range of motion. She has a centimeter leg length discrepancy, left longer than right. She has exquisite left trochanteric and proximal IT band tenderness. No lymphedema or overlying skin abnormality. Calves are soft and nontender. Quad and hamstring strength is well maintained. She is sensate about the legs. She walks with an antalgic Trendelenburg limp referable to the left hip.

X-RAYS: AP pelvis, AP, and lateral x-ray of her left hip show left and right hip replacements with about a centimeter leg length discrepancy, left longer than right. No trochanteric calcifications. No soft tissues abnormalities are seen. No loosening of implants is seen.

IMPRESSION AND PLAN: 4 - Health... has trochanteric bursitis imparted by leg length discrepancy for which I have recommended and placed a corticosteroid injection in the left trochanteric area, well tolerated and I have recommended a shoe lift for the right heel to equilibrate leg length so that she does not have recurrence of the symptoms. I would like to see her back in three months to see what effect this treatment has had.

P. Brodie Wood, M.D.
Olympia Orthopaedic Associates, P.L.L.C.
PBW/Int

1800

OPERATIVE REPORT

DATE OF OPERATION: 10/26/2001

PREOPERATIVE DIAGNOSIS: Severe osteoarthritis right hip.

POSTOPERATIVE DIAGNOSIS: Severe osteoarthritis right hip.

OPERATION PERFORMED: Right total hip replacement using the Zimmer cemented system, 12 stem, 0 mm x 28 mm neck head, 10 mm centralizer, 50 mm cup with 20 degree posterior offset liner.

OPERATING SURGEON: JOHN C. KOFOED, M.D.

ASSISTANT: DAVID GUZMAN, D.P.M.

ANESTHESIA: General.

ANESTHESIOLOGIST: DR. CHEN.

INDICATIONS: Severe osteoarthritis right hip.

DESCRIPTION OF PROCEDURE: Patient prepped and draped in the usual sterile fashion. Standard posterolateral incision made. Soft tissues reflected and the hip exposed. The external rotators and capsule reflected posteriorly off of the hip which was then dislocated and cut with the power saw. We then the used the _____ retractor to expose the acetabulum and reamed up to a 48 mm size and press fit a 50 mm screw in to the cup. I chose to put one single screw in to control rotation and there was an excellent bite. We then put in a 10 mm temporary posterior offset liner.

We then prepared the femur using the box chisel followed by the centralizer followed by the broaching up to 12. We tested our neck length and selected a size 0. We removed all components, bottle brushed the canal followed by the cement restrictor followed by the irrigation followed by the drying of the canal while the cement was being mixed, 2 bags of cement with 2 bottle of Tobramycin, which were then press fit into the canal with compression technique. We then placed in our femoral component, removing extraneous cement. While the cement was drying, we irrigated the hip extensively. We then tried our neck and head with noting good stability and position. There was

excellent stability throughout the hip. There was some concern about some posterior exposure of the femoral head at maximum flexion of 120 degrees and because of her large size, I chose to put in a 20 degree posterior offset liner which added a little bit more coverage posteriorly. The hip was very difficult to dislocate. With 40 degrees of internal rotation and adduction the hip was still in and at 120 degrees of flexion the hip was still in place. The wound was again irrigated extensively and closed in routine fashion over an auto-transfusion drain. Ancef 1 gm at the beginning of the procedure. Patient discharged to the recovery room in satisfactory condition.

JOHN C. KOFOED, M.D.

JCK/MRC72
The MRC Group
DD: 10/26/2001 11:34
DT: 10/26/2001 16:12
#85182

OPERATIVE REPORT

DATE OF OPERATION: 01/09/2004

PREOPERATIVE DIAGNOSIS:	Advanced osteoarthritis left hip.
POSTOPERATIVE DIAGNOSIS:	Advanced osteoarthritis left hip.
OPERATION PERFORMED:	Left total hip replacement.
OPERATING SURGEON:	JOHN C. KOFOED, M.D.
ASSISTANT SURGEON:	DAVID GUZMAN, D.P.M.
ANESTHESIA:	General endotracheal.
ANESTHESIOLOGIST:	Dr. Bui.

INDICATIONS: Advanced osteoarthritis of the left hip. She has alread has a right total hip replacement that has done quite well and she has chosen to go ahead with left total hip replacement.

The patient had a cemented prosthesis put in on the right side and tha has done well since 2001. There has been some literature that has com out since then indicating that people who are rather heavy with thickened bony cortices forcing us to use a smaller stem are at risk for breakage of that stem. For that reason we elected to go to a bony ingrowth prosthesis where we would have a much larger stem, much more durable with minimal risk for breakage. We also implemented the new trabecular metal cups.

PROCEDURE: The patient was prepped and draped in the usual sterile fashion in the right lateral decubitus position. Posterolateral incision made, soft tissue was reflected. The external rotators and the capsule was reflected off of the hip. We then went ahead and continued with the broaching process up to a size 12 and that was becoming quite difficult to continue and there is still obviously more broaching to do. We then went ahead with the reamers up to a size 14 and continued with the broaching up to a size 15 and then noted the medial offset stem was more appropriate to fill the medial defect. We press fit the stem and had an excellent tight fit. We then put on our femoral neck as about a -3.5 gave us good stability and good leg lengths. We then removed the trial components, irrigated and press fi our femoral component with a size 15 stem, -3.5 neck and a 28 mm head.

Of note, prior to this we did the acetabular part of the procedure which I failed to dictate earlier. We essentially reamed up to a size 50 mm and press fit in the new trabecular metal bony ingrowth cups. We had an excellent fit with good stability. We then placed our 10 mm temporary liner, reduced the hip and again appreciated excellent stability. We did not have to place any screws into the cup. This then concluded the procedure. All permanent components were inserted and the wound was irrigated in routine fashion. The wound was closed over an auto transfusion drain. We did have about 400 cc of blood loss with the use of the cell saver transfused back about a little over 300 mm of blood back to the patient. Sterile dressing applied. Ancef at the beginning of the procedure. The patient discharged to the recovery room in satisfactory condition.

JOHN C. KOFOED, M.D.

JCK/MRC72
The MRC Group
DD: 01/09/2004 10:28
DT: 01/10/2004 16:39
#364

DEPARTMENT OF HEALTH

MEDICAL QUALITY ASSURANCE COMMISSION
MEDICAL INVESTIGATIONS UNIT

MEMORANDUM TO FILE

DATE: September 19, 2011

CASE #: 2011-157968MD / William K. Harris, MD

TIME: 11:53 AM

RE: Complainant telephone interview

FROM: Joy Johnson, RN
Health Care Investigator 3

The Complainant stated she was a patient of the Respondent's for four years. She has TriCare for life. She stated her current PCP, Dr. Brennan, told her she "has something wrong with her kidneys" and she is "being referred to a kidney specialist." She is concerned because two of her sisters had allergic reactions to dye and both suffered strokes, one died and the other is impaired. This concerns her because two years ago following heart surgery she went into kidney failure. She stated she told the Respondent about her history of renal failure.

The Complainant stated the Respondent "never listened to her heart-never." In addition, he never explained any x-rays and never told her she had a heart murmur. There were ten in her family, all with heart problems, including an aneurism. The Respondent told her she was a diabetic but never did any follow-up. Reportedly, he also told her that her "heart was perfect" following an EKG. The shoe lift prescribed by Dr. Wood is not working well.

She believes the Respondent terminated her "because I have a big mouth." The Complainant talked about how bad the heath care delivery is in the U.S. She stated that in Scotland doctors would not get away with what they do here, "They'd be shot." She stated she was surprised that the health care in Scotland was better than here.

W. Kirk Harris, MD
FAMILY MEDICINE

6981 LITTLEROCK RD SW
TUMWATER, WA 98512
TEL. (360) 943-3633
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9/16/11

Joy Johnson, BSN, Investigator
Department of Health Medical Quality Assurance Commission
Box 47866
Olympia, WA 98504-7866

Re File #: 2011-157968MD

Dear Ms. Johnson:

Please excuse the tardiness of my response to your request. I have been out of town for the past week attending to my mother in the Intensive Care Unit of Sugar Land Methodist hospital after having had an anterior/posterior lumbar fusion and titanium rod placement surgery.

I will include in my response 1) comments to your original notification of complaint, 2) a chronological summary of the patient's treatment course with me, 3) the patient's entire medical record divided into specific sections including inter-office memos between me and staff members, and 4) specific responses addressing each of the patient's allegations.

I appreciate your investigating allegations and complaints to determine whether patient allegations are substantiated and require further action to be taken. This is an area that I believe is most important in the medical field at all levels, and observe the same practice in my own office. You will be receiving a copy of every page and paper in the patient's chart, organized by category, for your complete review. You will read that this patient's case has been complicated by many overlying factors, predisposing conditions, and concurrent illness states. I will describe to you how she presented her symptoms associated with specific conditions that caused her to have a delay of diagnosis, even by the specialists involved in the case.

In all, Ms.  was seen 39 times over a period of 5 years. The 70-year-old patient initially presented to the family practice clinic on 6/28/2006 with a complaint of shortness of breath, dyspnea on exertion, and bilateral hip replacement surgeries that were bothering her. She mentioned ongoing depression, insomnia, and fatigue related to the untimely death of her husband three years prior. She had moved to this area to be closer to her sons and grandsons, but had found the transition from southern California to Olympia quite difficult. Review of symptoms was otherwise minimized. Past medical history was significant for bilateral hip replacement surgeries (2002 and 2004), one of which had been complicated by renal failure, after which the patient commented that she had never felt "completely right." Medications were reviewed, physical exam performed, and impressions were noted. Plans were made to strategize increased dose Prozac at bedtime to take advantage of the sedation side effect it had – perhaps this would provide her with a more restful sleep and better mood control to improve her daytime energy level. She was already taking diclofenac 75mg (a Non-Steroidal Anti-Inflammatory

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Drug, NSAID) daily, and so her dose was increased to the usual twice-a-day dosing since her complete urinary review of systems was negative on presentation, despite the report of kidney problems associated with her hip replacement surgery 2 years prior. Bloodwork review from 7/2004 showed a normal creatinine, suggesting that she had return of normal kidney function and would be able to tolerate an increased-dose NSAID. Cholesterol bloodwork showed that her Zocor was keeping her in the controlled range. Other routine medications were refilled unchanged.

At follow-up visit I month later, she was not feeling better regarding depression, insomnia, racing thoughts, nor bilateral hip arthritis; despite increased doses of support medications, and so Prozac was changed to Lexapro to see if she would respond better to a newer, different Selective Serotonin Reuptake Inhibitor (SSRI). She was also given Valium with the idea that she could shut down her racing thoughts temporarily while the Lexapro "kicked in," and then the SSRI would take over for improved sleep quality, and the Valium could then be discontinued. She had just had hip replacement surgeries 2 and 4 years prior to this time, and requested a wheelchair to help with mobility concerns. It was felt that this was a bit extreme, but given the fact that she was ambulating with a cane and was insistent, I acquiesced.

Keeping to a monthly follow-up schedule, the patient was seen on 8/24/2006. At that time, she reported continued, significant depression despite the change in her SSRI, complaining that the Lexapro caused excessive sedation during the day. The Valium had helped with the quality of her sleeping but gave her vivid dreams, so both of the doses of Valium and Lexapro were halved to see if she might benefit from medicines that she was already familiar with, but in lower doses. Please note that even though a comment at the end of each note (mostly for billing purposes) indicates that the patient was seen for 10-15 minutes, it was quickly being discovered by me and the front desk that this patient would require at least a 30-minute time slot because of the length of time required to get to the business of the visit. For instance, during this visit, I listened to her discuss her sons, her grand-sons, her son's now-lesbian ex-wife, her late husband, strained relations with her sisters in Ireland, and being homesick for California. These long pronouncements were never hindered nor cut short by me, because I felt that perhaps I could serve as a sounding board for this patient who seemed to need a bit more hand-holding that the average. I actively listened, commented, and participated in non-medical-related conversations with her; feeling that it was valuable simply for the furthering, solidifying, and nurturing of our doctor-patient relationship.

The next visit on 9/27/2006 brought good news in that she was now tolerating and benefitting from full doses of combination Lexapro and Valium with significant improvement in her depression and sleeping despite ongoing stressors with her family issues.

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Six weeks later, she came in with an ear infection that was treated with Augmentin. Because Valium had become ineffective for her insomnia, she was switched to Ambien CR 12.5mg qhs, and other medicines were continued unchanged.

Two months later, on 1/15/2007, she complained of palpitations and dizziness. She denied specific chest pain, heaviness, and shortness of breath at that time. Blood pressures were in good control on triple therapy. Labs from 2004 and 2005 were reviewed, and full interval labs were drawn. Of note is the fact that the patient refused to have her weight measured, as she did at the majority of her visits. Her exam was unremarkable except for newly diagnosed atrial fibrillation, confirmed by EKG. Bloodwork was unremarkable except for elevations to BUN & creatinine. The mean creatinine level in elderly patients is known to be higher than younger patients, and it could have been further/artificially elevated by relative dehydration as evidenced by her higher BUN; and so no change was made as a result of this bump in her kidney function indicators. The more important issue was addressing her heart rhythm change. The condition was discussed at length, explaining the natural history of atrial fibrillation, its causes, its prognosis, its hemodynamic impact, and treatment. She was started on Digoxin in an attempt to reverse a newly diagnosed condition, which if treat early, could conceivably resolve without recurrence.

On 1/30/2007, she presented with a full-blown flare of gout in the right great toe. Because she had tolerated diclofenac well, but because it was not specific for gout, she was switched to Indocin and started on a low-purine diet. She reported 2 weeks later that the Indocin had not worked as well for her toe pain, and so was restarted on the diclofenac. At that same 2/13/07 visit, she reported that the Digoxin had completely normalized all cardiac symptoms (including no dizziness), and her cardiac exam was within normal limits with no murmur nor leg swelling.

On 4/3/2007, she complained of ongoing gout pain and new right knee pain such that she was ambulating with a cane. Her knee exam was unremarkable. At the same time, she had had some dizziness and occasional flashing lights in her vision despite a trip to the eye doctor for full eye exam. No retinal detachment nor glaucoma was found, and so she was sent for imaging studies: knee films confirmed degenerative joint disease (DJD) and a CT scan of her head showed no acute intracranial abnormality that would explain her symptoms. She again described at length stressors at home with her sons, selling her house, and other complaints. She was given Midrin as needed for her headaches. Because of ongoing gout pain with toe tophus evident, she was started on Allopurinol in an attempt to decrease the intensity of her gout experience. Because of the possibility of the NSAID causing or contributing to gastritis, Prilosec was started to "cover" her stomach.

Patient was seen 6 months later on 10/10/2007 accompanied by both of her sons with myriad complaints all pointing to uncontrolled anxiety & depression. She had been off

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all SSRIs for 9 months, and so it was suggested that she restart Prozac, in addition to continuing all of her other medicines unchanged. She was significantly improved at recheck visit 6 weeks later, but some Ambien was restarted to assist with residual insomnia complaints.

The patient was diagnosed at her 3/27/08 visit with new-onset diabetes while being evaluated for a urinary tract infection. In addition to being treated with antibiotics, she was counseled at length regarding prudent diabetic diet, weight loss, exercise, and lifestyle changes. She was provided with test strips and lancets, told to return for blood sugar diary review in 2 weeks, and was sent for blood testing which she did not obtain until a month later.

When she returned on 4/23/08, I listened to her talk about her trip to Texas. Her son, Greg (the "difficult" one), is divorced and has two sons, Matt and Travis. Travis lives in Texas and had had a new baby that Ms. 4 - Health... went to visit. In the meantime, Travis had divorced his wife who turned out to be a lesbian. While the Ms. 4 - Health... was visiting, the ex-wife's lesbian lover decided to go back to her husband, creating all kinds of family turmoil with Travis, his ex-wife/lesbian, and their new baby girl, along with the rest of the family. I only mention this scenario specifically, because Ms. 4 - Health... writes in her complaint that I never listened to her – I will comment on this later. (By the way, Ms. 4 - Health... is one of 10 children; 3 of whom had angina and 3 of whom have died (2 from tuburculosis). Her husband was in the Air Force, was a bad alcoholic, and was exposed to Agent Orange, which Ms. 4 - Health... is convinced contributed to his prolonged and untimely death. Her other son, Shawn (the "laid back" one), has two sons, Greg and Andrew). CBC, Complete Metabolic Panel (including a normal creatinine for her age and weight), thyroid testing, and high A1c confirming new-onset diabetes were discussed and explained line by line, as is my usual practice, and Metformin was prescribed but which she never took until 2010, electing to treat her diabetes with diet and life-style changes instead. She continued on Valium to help her to manage her stress and anxiety symptoms.

At her 5/22/08 visit, the patient reports that she was shopping in a scooter at Wal-Mart when she was bumped by a worker. This so jarred her, that it worsened her hip pain. She reported having bilateral hip pain ever since she had her hip replacement surgeries, and that that is why she had been using a cane this whole time. With the reassurance of normal kidney function testing on recent bloodwork, the patient was told that she could continue treating her musculoskeletal pains with NSAIDs.

On 6/5/08, while reviewing her medication list with her, I discovered that she was taking two NSAIDs and two SSRIs for her various complaints, and had to counsel her to limit these classes of medications to a single med. After the clarification was explained, she was encouraged to continue her excellent diet-control of diabetes and all of her other medicines unchanged.

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Patient was seen by William Millar, PAC in the after-hours, walk-in clinic for a gout flare on 8/27/08 and was treated with colchicine. Incidentally, it was noted that she had a heart murmur and carotid bruit, but even though the patient expressed an interest in evaluating these further, she did not get around to testing for another year. She was more focused on visiting family in Scotland at the time.

Cardiac and pain symptoms were well-controlled at recheck visit in 10/23/08, but she was started on Lunesta for ongoing complaints of insomnia. Maintenance recheck visit on 2/9/09 was equally unremarkable with no new complaints, ongoing issues well controlled on current medications, and all reassuring lab results including a normal A1c and creatinine.

After pulling luggage through airports on her Scotland vacation, she complained of neck and shoulder pain and was diagnosed by C-spine MRI on 5/14/09 as having multi-level degenerative disk disease and spinal canal stenosis as an etiology for her discomfort. She followed up with neurologist, Dr. Lang, 6/15/09 regarding pain radiating down the right arm into hand tingling. His evaluation included carotid ultrasound imaging which showed bilateral carotid plaque which was then thought to be an explanation for the bruits heard by PAC Millar. Her pain resolved with conservative care until she had 2 incidents occur.

At the 10/8/2009 visit, she reported that a deer bumped off of her car while she was driving, and then 12 hours later, her car was hit from behind while she was using a drive-up ATM. She reports that her car slammed into the pole in front of her, again jarring her neck and renewing her neck pain and radiating hand tingling. At the same time, she was having left chest aching, but denied any associated shortness of breath, dizziness, sweats, or radiating discomfort into the left arm. The patient was very upset by these symptoms, and continued to complain of symptoms related to these car incidents for nearly a year afterward. She was referred to multiple-modality South Sound Physical Therapy for treatment of her neck pain complaints which she participated in; and for interval bloodwork, which she did not obtain.

At the 11/12/09 visit that she complained of feeling "out of sorts;" with light-headedness, continued neck pain with limited range of motion, right hand tingling and upper shoulder pain. Neck exam confirmed her complaints with decreased ROM, but she appeared to be tired and less animated with decreased energy level. All of these complaints were still thought to be due to her car accidents, and so she was given a muscle relaxing medication for neck and shoulder spasm pain and referred back to neurologist, Dr. Lang.

She became increasingly depressed, frustrated, and tired because of the significant impact this accident seemed to have on her independence and ability to perform activities of daily living. She had minimal change in her symptoms, but also never indicated any hip-, knee-, nor cardiac-specific symptoms. It was acknowledged to the patient that it may

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take several months for her to recover from her MVA-related injuries, and the patient indicated understanding at that time.

She was not seen in the clinic from 12/10/09 through 3/9/2010. She had simply been continuing with NSAID and physical therapy with no improvement in her neck pain nor headaches. She complained of difficulty fastening her seat belt with either arm, that her seat belt was pressing too tightly on her shoulder and neck, and that she had to use her mirrors more than usual while changing lanes because of decreased neck ROM due to discomfort. No mention of chest pain, shortness of breath, cardiac nor lower extremity symptoms occurred during these visits. It seemed, also, that at this point she should have had sufficient recovery from any MVA-related injury; and so her continued disability was then more attributed to her long-standing, pre-existing, C-spine DDD and stenosis which could have been exacerbated and accelerated by her MVAs.

At her 5/27/10 visit, it was still unclear as to why she had poor energy level and excessive sleeping. Her other complaints of aching left-chest pain, headaches, depression, and insomnia were thought to be injury-related and that she simply was healing quite a bit slower than usual, as diabetics do. Patient was bright, alert, sharp, and talkative, but complained of mental deterioration, and decreased ambition because of her physical condition. She was started on an additional depression medication and a different medication for insomnia. Full bloodwork revealed diabetes out of control with an A1c of 7.9. CBC, TSH, urinalysis, and CMP were unremarkable – it was felt that her BUN and creatinine were up at that time because of dehydration caused by the patient having average blood sugars of 180. It was explained to her and her son that despite her good efforts with diet, her diabetes had progressed to the point that now it was imperative she start Metformin. Uncontrolled diabetes was a completely appropriate explanation for her fatigue, polyuria, polydypsia, blurry vision, and anhedonia. Even a fingerstick at 2pm on 6/3/10 showed a blood sugar of 273.

At recheck visit a month later, she had normalized her blood sugars on Metformin, but still had shortness of breath, fatigue, and unsteadiness unchanged from her previous visit. No new complaints were forthcoming to direct testing or treatment, and so her current therapy was continued unchanged.

She was seen after-hours on 9/9/2010 complaining of dizziness and lower blood pressures. She was increasingly depressed and crying daily; commenting that her sons were treating her badly, were completely tapping her out by constantly asking her for money, were ungrateful for everything that she had given them through the years, would not even come over to her house to help out by mowing her lawn; and as a result of all of this, was simply thinking about moving back home to Scotland to leave the whole mess behind her. Her cardiac exam was benign, but because of lower blood pressures, atenolol was discontinued. She reportedly weighed over #250 when she first came to the clinic in 2006, and it was conceivable that with her weight loss and diabetic dietary efforts that her

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blood pressure could have decreased sufficiently at a weight of now #190, thus requiring fewer antihypertensive medications.

Her visit on 9/21/2010 was much the same with continued and progressive symptoms and physical findings such that her second blood pressure medication, Zestril, could be discontinued. It was discovered with full bloodwork, however, that she had a UTI which could have explained her physical deterioration. Otherwise, thyroid, blood count, A1c, and CMP were all normal; including her BUN and creatinine (kidney function tests). I was optimistic that she would brighten up and re-energize with antibiotic treatment and increased blood pressure.

Complaints of shortness of breath and dyspnea on exertion were initially attributed to depression, pain, hypertension, obesity, and deconditioning. Her cardiac exams were unremarkable and she did not have swelling in her legs nor crackles in her lungs to indicate cardiac compromise. During the majority of her visits throughout the 5 years, there were so many overlying issues that cardiac symptoms were never mentioned nor indicated. This was certainly the case with her MVA-related neck and shoulder pain complaints dominating much of her visits from 10/2009 through 5/2010.

Two weeks later, her bladder infection symptoms had resolved and she was off 2 of her previous blood pressure medicines, but was still having low pressures. At that visit on 10/4/2010, she complained of well-localized, sternal chest tightness with associated shortness of breath, fatigue, and dyspnea with exertion. She still spoke at length, however, about depression, anxiety, unsupportive sons, her grandson's serious car accident, and moving to Scotland. Exam and office EKG were stable and reassuring, but because of the persistence of her symptoms she was sent for a nuclear cardiolite study to evaluate her for coronary artery disease.

Cardiologist, Dr. Li, performed a Chemical Nuclear Stress Test on Ms. 4 - Healthc... 10/29/10, and it was found to be normal with no indication of heart muscle ischemia.

She was then referred to cardiologist, Dr. Brennan, on 10/29/2010 who felt she had Class 3 limiting effort angina and dyspnea, noting that she had ST segment depression during the test. He prescribed nitroglycerin tabs because of the possibility of coronary artery disease contributing to her symptoms, and ordered a heart catheterization with intervention if indicated (balloon, stent, bypass, etc.).

The patient underwent angiography on 11/2/2010 and was found to have clear coronary arteries and normal left ventricular function. Follow-up echocardiogram the same day demonstrated that the patient had a significant aortic valve stenosis. At this time, I would like to formally and respectfully disagree with the comment in Dr. Brennan's progress note that states that the patient had "marked chest pain," and an "impressive history of angina." Nowhere in any of my dealings with her did she state such, nor in Dr. Li's notes

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did she indicate that she had either of these symptoms. Furthermore, if Dr. Brennan was so surprised about her condition, the delay of evaluation, and saw her normal nuclear study; then why didn't he order the echocardiogram first and save her the anxiety, expense, discomfort, and risk of an angiogram?

The same day, Ms. 1 - DOH L... was then sent to cardiac surgeon, Dr. Quinton, who assessed her "progressive chest pressure, some pain, some dyspnea on exertion, and increasing tiredness" that had become "progressively symptomatic." With the real diagnosis firmly established, it was easier to more accurately describe her symptoms in the record.

I spoke at length with Dr. Brennan on the phone 11/4/2010, and information regarding her condition was exchanged. I asked him about her presentation and if I could have done anything differently. He told me that he would not have done anything different until she had become symptomatic with complaints such as congestive heart failure, shortness of breath, syncope, or chest pain. I also talked at length with Ms. 6 - Ident..., apologizing for the delay of diagnosis by me and both cardiologists, explaining the progression of events, and what she could expect in the coming days and weeks. I was on the telephone for an hour total, speaking with Ms. 6 - Identit... and Dr. Brennan. During this time, the patient expressed her anger with me (as well as that of her sons), saying that depending on the outcome of this surgery, I could expect some correspondence from her lawyer. She said that she had been complaining of these symptoms for a long time, and felt as if I had done nothing for her. She told me that I was lucky she didn't have her son come to the office to "have a talk" with me as well. I apologized again for the circumstances surrounding her nonspecific and overlapping symptoms and her heart condition diagnosis delay and wished her well with her aortic valve replacement surgery.

The patient underwent an unremarkable aortic valve replacement surgery through an upper mini-sternotomy incision and recovered nicely. She was discharged from Providence Hospital on 11/13/2010 and had Providence South Home Health visiting her during the month of December to check her wound, and assist with her mobility and recovery.

When she was seen back in the family practice office on 1/5/11, she was doing well with an increased energy level, no shortness of breath, no dyspnea with exertion, no fatigue, nor depression. She was pleased with the outcome of her surgery, but still was upset about the delay of diagnosis. We made plans for the nurse to call and "check in" with Ms. 1 - DOH Li... on a weekly basis to troubleshoot any issues that we may facilitate for the next 2 months, and this was done with positive feedback from the patient. On that date, her CBC and CMP were all normal, including kidney function (BUN & creatinine) except for low potassium, low chloride, and elevated blood sugar. She was started on supplemental oral potassium and told to step up her nutritional intake, continuing to manage her diabetes.

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At her 1/26/2011 visit, things seemed to return to their usual pattern with long, talkative commentaries, various issues being raised, and maintenance diagnoses being managed (low potassium, insomnia, gout pain, cardiac rehab, and headaches). The same for her 2/28/2011 visit (gout pain, breast ringworm rash, unappreciative/troublesome sons through the years, fatigue, back discomfort, and a second increased potassium dose). She was sent to podiatrist, Dr. Stone, 3/9/2011 for consultation regarding her persistent foot pain, and he added colchicine to her Allopurinol treatment.

Routine followup care on 3/16/11 involved discussion and management of potassium, leg swelling after surgery, blood pressure control, depression, insomnia, and persistent post-operative fatigue with left leg unsteadiness with ambulation. This time, blood work showed normalization of her potassium on increased-dose oral replacement, continued normal CBC, and baseline kidney function.

At her last visit on 4/20/11, six months after her heart surgery, she was having no gout pain, but complained of worsening left knee pain radiating up into the thigh causing limping with ambulation. Knee exam showed some generalized swelling to the left knee; and so she was given pain medication and sent for repeat knee films to compare to the severe degenerative changes we saw on her 4/6/2007 films. We called her with results, and this seemed to set off a barrage of phone calls from the patient over the next several days that eventually culminated in the office staff and my becoming incredibly frustrated with an unsatisfiable patient. She insisted that she was having hip pain and that we took x-rays of the wrong thing. She insisted on our obtaining records from hip films obtained 10 years prior from her California physician. She had extended, heated arguments with every one of my staff members, insisting that we had done things wrong and that we should have obtained hip films. She finished by saying, "To Hell with it! I'm gunna take care of this once and for all," and hung up.

It was at that time that as a practitioner with a fully capable staff, we decided that in this patient's opinion we could never be enough for her, and that she had threatened and abused us sufficiently enough to warrant discharge. That day, we sent a certified letter indicating that we would no longer be her primary care office because we were unable to meet her medical needs. We suggested that she seek out the services of another physician for her ongoing medical needs.

The complaints by the patient about my care of her are inaccurate, inflammatory, and exaggerated. I will comment on each of the points that she makes in her statement of medical complaint.

There were times that she complained of heart palpitations, but it was not continually nor at every visit for over four years. When it was appropriate to investigate her heart, based on her specific complaints, an EKG was performed. On one of those investigations, atrial

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fibrillation was diagnosed, the patient was treated with digoxin, the condition resolved, and all heart complaints were then absent for a time.

The separate, non-arrhythmia complaint later discovered to be aortic valve stenosis did indeed progress over time to the point that she became more tired, listless, and out of breath. In my conversation with Dr. Brennan, he told me that he would not have done anything differently until she became symptomatic. Once an aortic valve stenosis is identified, patients usually undergo serial echocardiograms to follow their progression. It may start out greater than $2cm^2$, but then may be followed with serial echocardiograms every 6-12 months until it reaches a critical $<1cm^2$ size. At that time, the patient usually goes for valve replacement surgery. It just so happens that until October 2010, Ms. Tuitele never had EKG nor chest x-ray changes (enlarged left ventricle, altered heart size/shape, congestive heart failure with pulmonary edema) nor symptoms (syncope or chest pain) to suggest further studies were warranted. Even Dr. Quinton documented that she had "progressive chest pressure, some pain, some dyspnea on exertion, and increasing tiredness" that had become "progressively symptomatic. Those seem to be rather mild comments coming from a man who is about to replace a heart valve.

Her depression and anxiety were pre-existing to her establishing care with me, and were ongoing concerns that we continued to battle. She underwent trials of many medications in an attempt to control these prominent symptoms, always with mixed or temporary results.

As a rule, throughout my years in the practice of medicine, I have never decreased my optimism regarding the resilience of the human condition. I have been amazed at the vigor with which people live their lives – no matter how old they are – and have never told any patient that their symptoms are occurring just because of their age. I feel that there will always be another approach that can be taken to any complaint, and have gone to great lengths striving to improve patients' qualities of life.

My chart reflects 39 visits and 39 sets of vital signs during the years that Ms. 4 - Health... was under my care. Also noted are the many times that she refused to have a vital sign measured. A visit where we are discussing depression, anxiety, and insomnia or neck pain that impairs her driving ability does not necessitate that I lay my stethoscope on her chest and listen to her lungs. Each visit Ms. 4 - Health... had was tailored to her chief complaint. My common practice is to have the nurse obtain vital signs and for me to address the concerns at hand, trusting that my capable nurse has measured blood pressure, pulse, respirations, and weight accurately. If Ms. 4 - Health... felt that she received inadequate care because I personally did not measure her blood pressure, then she should have voiced that preference, and I would have happily complied as I often have with many other patients.

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Her EKGs performed in my office are dated 1/15/2007 and 10/4/2010. These were not done after repeated requests, nor did I reluctantiy agree to do them. When it was appropriate to evaluate her heart because of a specific complaint, I appropriately obtained an EKG and reviewed the results with the patient in the room after she had dressed. The first EKG diagnosed atrial fibrillation and the second EKG was normal. Appropriate action was taken after each test was done. I do not have independent recollection of the patient insisting repeatedly that I prescribe more tests for her heart, nor does my chart reflect that.

At the visit on 10/4/2010, she complained of well-localized, sternal chest tightness with associated shortness of breath, fatigue, and dyspnea with exertion. Exam and office EKG were stable and reassuring, but because of the persistence and progressive nature of her symptoms she was sent for a nuclear cardiolite study to evaluate her for coronary artery disease. To clarify, she did not go to the cardiologist of her own accord and did not order any heart studies herself Of note is the fact that even after being evaluated by 2 cardiologists, it was still felt that she had coronary artery disease necessitating an angiogram with full counseling and consent being obtained for a coronary artery bypass graft. Only after the angiogram showed clear coronary vessels was the echocardiogram obtained showing the true etiology of her symptoms.

Indocin, Naprosyn, diclofenac, and indeed all NSAIDs including aspirin have a precaution regarding kidney function. The patient was monitored for kidney function throughout the years that she required treatment for her gout, MVA neck strain, shoulder pain, hip arthritis, knee DJD, etc., and her BUN and creatinine were always within an acceptable range. I paid as much attention to her kidney function as was necessary when managing all of her pain complaints, and with the assurance that they were not being compromised by my therapy, proceeded on to the next issue.

Ms.  has known, severe DJD in the left knee with bilateral hip replacement surgeries from 2002 and 2004. Complaints of hip pain were expected due to the fact that she had had hip replacement surgeries. She has ambulated with a cane for a decade because of hip pain. Besides a gout flare of the great toe on 1/30/07, the next time she mentioned any lower extremity pain was on 4/3/2007 when she complained of right knee pain thought to be due to "wear-and-tear" arthritis. I do not recall nor see documentation about discussions regarding trouble with her hip implants. The reasons for my ordering a knee x-ray were two-fold: 1) it was her chief complaint that day, and 2) to obtain an interval assessment on known knee degeneration that might necessitate a visit to the orthopedist to either justify steroid injection or knee replacement surgery if she had progressed to "bone-on-bone" DJD. During the majority of her visits throughout the 5 years, there were so many overlying issues that knee and hip pains were never mentioned nor indicated.

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Regarding the situation where Ms. 4 - Healthc... was trying to obtain records from her California orthopedist to determine whether or not she had the kind of hip replacement joint implant that had been recalled, all I can say is that Ms 4 - Healthcar... did not complete a signed records request for us to fax to Vacca Valley. No facility, except under special circumstances, is allowed to send medical records without a patient signature. Apparently, the specific information that she was seeking was not adequately conveyed to us nor requested and signed by her in order to obtain the information she was seeking. My prescribing pain medication was only a temporary, stop-gap attempt at relieving her complaint of worsening knee pain during the time that we were collecting more information that would help to direct our therapy.

If she felt so strongly about my disregard for her, my extreme neglect of her, my improper and lack of adequate patient care, and incompetence, then why would she return to my office for another 5 visits over a period of 6 months? During every visit following her aortic valve replacement surgery, she reminded me that I was "lucky" that things turned out the way that they did or else I would have had a lawsuit on my hands. This did not foster an open, unobstructed, cooperative, empathetic doctor-patient relationship. Because she included such a barrage of medical and non-medical complaints during visits regularly, it was often difficult to discern what her true medical concerns were versus what she just wanted to vent about. Please realize that each progress note is a condensed distillation of the huge volume of information that the patient would expound upon at length at each visit, and that the vast majority of them lasted in excess of 30 minutes, especially when she was accompanied by any family member.

As for the comment that I treated Ms. 4 - Healthc... with disregard, I disagree. As for the comment that I did not listen to her, I disagree. I would not be able to comment to the degree and specificity about many issues that I have unless I had actively listened to and remained attentive to her commentaries and concerns. I'm sorry that this patient feels that she received inadequate care from me and my staff. As for what could have been done differently, I feel the Physician Assistant, I, and the 2 cardiologists involved in the case could have ordered her echocardiogram earlier and discovered her aortic valve stenosis in a more timely fashion.

Thank you for your time in reviewing this matter. Should you require further clarification regarding any of my comments or records, please do not hesitate to contact me.

Sincerely,

Harris, MD

W. Kirk Harris, MD

Risk:	High	Med.	Low
CAD			
Cancer			
Diabetes			

Allergies

4 - Healthcare information readily identifiable to ...

Medication	Visit Dates												
	10/29/10	1/6/11	1/31/11	11/24/11	3/11/11	2/28/11	3/9/11	3-1-11	3-16-11	3-23-11	4-10-11	4-20-11	
Prozac 40mg	30 1 refill												
ASA 81mg QD							Probe Trust	~~60~~ RFx1					
K-Dur 10meq 1 po QD (Lasix)		90 x1y						60 RFx1					
Dalmane 15mg 1 qhs			30 x1										
Allopurinol 100mg 2 qd-bid				60 x1		120/2	+10	✓	Q10	✓	✓		
Tylenol 500mg 4 times a day													
K-Dur 10meq 1 po Bid					60/1								
Lotrisone cream bid 15gm						15gm x1							
Colchicine 0.6mg BID							x1w						
Furosemide 40mg							30 2						
metoprolol 25mg							60 2						
Colcrys 0.6mg 1 po bid								~~60~~	60 RFx1		60 1		
metformin 500mg 1 po bid										60 1y			
Vicodin										No Refill			
Percocet												40 NR	

000031

Allergies

Codeine

4 - Healthcare information readily identifiable t...

Visit Dates

Medication	9-27 08	10-7 08	10-23 08	2-9 09	9-8 09	10-8 09	11-12 09	12-9 09		2/11 10	5-27 10	6-3 10	
ColChicine 0.6mg 1 qh	12 NR												
Fluoxetine ~~20mg~~ 40mg 1 QD		30 3	✓	30 1Y		90 x1y	✓	✓	✓	✓	✓	✓	✓ D
Lanoxin 0.25mg 1 QD		30 3	✓	30 1Y	30 x3	90 x1y		✓	✓	✓	✓	✓	✓
INDOCIN 25mg TID			90 1Yr	✓		90 x1y		90 prn	✓	✓	✓	✓	✓
ATENOLOL 50mg QD			30 1Yr	✓		30 x1y		✓	✓	✓	✓	✓	✓
SIMVASTATIN 40mg QD			30 1Yr	✓		30 x1y		✓	✓	✓	✓	✓	✓
HCTZ 25mg QD			30 1Yr	✓		30 x1y		✓	✓	✓	✓	✓	✓
ZESTRIL 20mg QD			30 1Yr	✓		30 x1y		✓	✓	✓	✓	✓	✓
PRILOSEC 20mg BID						30 x1y		✓	✓	✓	✓		
SOMA 350mg							50 x1	INEFFECTIVE					
ROBAXIN 750mg 1po bid-TID										60 RFx1			
Wellbutrin SR 150mg BID											60 x2		
Augmentin 500mg BID											20 NRF		
Dalmane 15mg QHS							SLEEPS VERY WELL!				30 x2	✓	✓
Metformin 500mg BID												60 x1	✓
	8.3 10	9.22 10	10.4 10										
metformin 500mg BID	60 6												
Bactrim DS 1po bid		20 0											
ATIVAN 0.5mg BID pm ANX			30 2										
START LOVAZA 1000mg 1 po qd			30 1										

Risk:	High	Med.	Low
CAD			
Cancer			
Diabetes			

Allergies

CODEINE

4 - Healthcare information readily identifiable t...

Medication	Visit Dates										
	10/10 07	10/22 07	11-19 07	11-19 07	3-19 08	3/27 08	3-31 09	4-23 08	4-30 08	4-29 08	6/18 08
Prozac 20mg 1qd	30 6	✓				30 x6					✓
Hctz 25mg 1qd	30 6					30 x6					✓
Atenolol 50mg 1qd	30 6			30 x6		30 x6					✓
Zocor 40mg 1qd	30 6					30 x6					✓
Lisinopril 20mg 1qd	30 6			30 x6				30 6			✓
Digoxin 0.25mg 1qd	30 6					30 x6					✓
Diclofenac 75mg 1 b.i.d	60 6	ONLY ONE!		ONE!		60 x6					X
Indomethacin 25mg Tid								90 6			✓
Ambien CR 6.25mg QHS	INTERFERE		30 x2	DOPEY NEXT DAY		30 x6					
Simvastatin 40mg Bid				30 x1							
AMBIEN 10mg						30 x6	HALLUCINATES				
XANAX 0.5mg QHS prn						30 x2	off				
Lancets						100 x1y					
Test Strips						100 x1y					
Bactrim DS						1y NR	DC				
Macrobid Bid UTI							#14 NR		X		20 NURF
ALLOPURINOL 100mg QD								30 6			X
VALIUM 10mg QHS								30 6			✓ OFF 2° FATIGUE + SEDATION
Metformin 500mg									60 x2	60 2	✓
NAPROSYN		HELPS	HIP	PAIN!							✓
MILDRON (DURADRON) QHS prn HA's.											✓
PRILOSEC											✓

Risk:	High	Med.	Low
CAD			
Cancer			
Diabetes			

Allergies

CODEINE

4 - Healthcare information readily i...

Visit Dates

Medication	6-26-06	7-27-06	8-24-06	10-11-06	11-6-06	1/15/07	1/30/07	8/13/07	3-22-07	4-3-07	5-10-07	5-24-07
Hctz 25mg 1 qd	30 · 1	✓	30 · 3		30 · 6	✓	✓				30 · X 6m	
Atenolol 50mg 1 qd	60 · 1	✓	30 · 3		30 · 6	✓	✓				30 · X 6m	
SIMVASTATIN Zocor 40mg 1 qd	30 · 1	✓	30 · 3		30 · 6	✓	✓				30 · X 6m	
Lisinopril 20mg 1 qd	30 · 1	✓	30 · 3		30 · 6	✓	✓				30 · X 6m	
Prozac 20mg 2 qhs	60 · 1	Δ (INEFFECTIVE)										
Diclofenac 75mg 1 bid	60 · 1	✓	60 · 1		60 · 6	✓	✓				60 · X 6m	
VALIUM 10mg QHS		30 · 2	30 · 1 VIVID	30 · 5 DREAMS	Δ							
Lexapro 10mg ½ · 1 qd		30 · 2	30 · 1 EXCESSIVE SEDATION	30 · 6	OFF							
~~Diazepam 5mg~~ AMBIEN CR 12.5mg				30 · 2								
Augmentin 500mg 1 bid				20 · NR								
VALIUM 5mg BID prn					30 · 1	✓		30 · X 6m	✓	✓	STILL ANXIOUS	
Digoxin 0.25mg 1 qd					30 · 1		30 · 1 yr		✓	✓	30 · 4	
Indocin 25mg 1 tid						50 · 2	off (GI issues)					
ALBUTEROL DAILY												
Prilosec 20mg									30 · X 2			prn
Allopurinol 100mg 1 qd									30 · X 2			
TRUSOPT										15gm · X 2		
MAXERAN 1 qid HA										40 · X 2	✓	prn

DATE	AGE	TEMP	RESP	PULSE	BP	WT	PAIN	TOB	CHIEF COMPLAINT	COUNSEL
11/12/09	73		18	57	140/62	NO		Ø	MVA	Pox 97%
12-7 CM									R/S	
12-10 09	73		22	62	136/72	NO		C	R MIC PM INTO R SH. paperwork PT + MASSAGE TIW	
3/9 10	74		20	63	144/82	NO		Ø	NIK PM ↓↓ INTO ARMS. ↓↓ (B) SH. ROM: post accident ✓ R NIK 45°, L NIK 25°	97 POX
5-27 10	74		20	58	150/87	NO		Ø	L. CP ↑SLEEP AM ORT, ↓NAG, ↓APP, ↓WT y/u BP R. EAR DEAFNESS HR's 112-121	FX 96
10/3 10			16	66	146/80	200		C	Go over Labs	Pox 96%
10-1 10	74		18	70	128/78	NO		Ø	UNSTEADY ON FEET. L. SH DISCOMFORT. DOE CONSISTENT go over labs 93-154	Pox 97
9/9 10	74		20	57	100/52	NO	190	Ø	DEPRESSED RE: SONS. CRIES DAILY. UCS) DIZZY RBS: 137	→LIFE-LINE! Pox 97
9/21 10	74		18	85	136/82	190	BS 2pm: 137	C	SLOWLY CRAWLS OUT OF BED. DEPR! LAPP. BP follow BP LOW, LETHARGIC, HASN'T FELT GOOD FOR 1 YEAR	Pox 96% 75-165
9/4 10	74	98°	20	95	139/76	195	GRANDSON MVA.	C	CHEST TIGHT > 2d / SOB / DOE / TIRED BP f/u SHARPNESS, No AMBITION! 126-161/54-82 morning BS 95	Pox 95% 96
1/5/11	74		18	69	148/82	188.5			F/u Open heart surgery N/C	BS: 182 pox: 96 FLU SHOT ✓
120 11	74		18	69	130/68	190		Ø	(R) foot ankle swollen, pain.	Pox 98%
2/8 11	75		20	72	122/62	202		C	WANTS TO WALK! fatigue. Gout (R) feet - pain across back.	Pox 98%
3/16 11	75		20	68	140/90	199.5		Ø	INSOMNIA POSTPONE BETTER ON COLCHICINE/ANOPURINOL med ✓ for Gout	pox 96
4/20 11	75		16	76	136/84	200		C	WORSENING ↓3W. NOTR Drue Tinto thigh pain	

4 - Healthcare information readily ide...

DATE	AGE	TEMP	RESP	PULSE	BP	WT	PAIN	TOB	CHIEF COMPLAINT	COUNSEL
6-26-06	70		18	76	134/96	NV 205		NO	High BP	
9-27-06	70		20	80	143/78	NV		NO	Test Results	
8-24-06	70		18	82	140/86			∈	f/u Lexapro	
9-27-06	70		22	82	131/63	NO		ϕ	f/u Lexapro	
11-16-06	70		20	71	137/71	NO		∈	paperwork, flu shot	
1-15-07	70		21	71	100/84	NO		ϕ	√ BP, Med √, dizzy, √ Ⓡ third toe	
1-30-07	70		20	74	147/74	NO			Ⓡ foot swelling	
2-13-07	71		18	76	129/72	NO		∈	f/u Intocin, ♡ meds	
4-3-07	71		18	74	126/64	NO		∈	Ⓡ knee pain (Awakens Her; Feels Unwell. Aches Sees. Hears. Dizziness)	
10-07	71		18	REG 72	147/88	NO CANE			Ⓡ ear Infection, fatigue (Some Drainage, Odor; Seeing Halos; Eyes Good) R Forearm 6mm	
10-10-07	71		16	66	131/88				medication f/u, Go over Rx's (HA EKG? Ⓡ Dime Spot)	
11-14-07	71		20	REG 78	130/76				unable to sleep. dizzy	
3-27-08	72		67	18	134/71			∈	Bpr, medication (Not x2; BS 248) RFUA: Gluc+++ Nitrite+++	
4-23-08	72		59	16	130/60			∈	BS f/u 75-167 Pox 97	
5-22-08	72		9		145/89			ϕ	F/u BS 100-129 96%	
6/5/08	72			61	137/78				go over meds HIVis 90-104 92%	
10-15-08			18	61	136/72			∈	Talk c pt's son RE: meds (Fatigued, "Doped up", Tired, Unsteady, "Slurring" words 90-107)	
7/24-08			18	99	136/85			∈	BS f/u.	
8/27-08			16	65	152/85				foot	
9-23-08	72		18	72	147/80	205		∈	Rx's, flu shot 87-105	
2-29-09	72		18	70	144/79	NO			f/u dentist 87-102	200036
5/13-09	73		18	60	140/68	NO		∈	R. MK PN. MM x2w. (Whole Hand + Arm Tingling w/ Drawing, Aches Past Pins & Needles in Ⓡ Hand pox95% Sleeping Tingles Left & Both Hands Examined At Arm 12h Later → MK PN → Hands, Mine	
10/8	73				149					

4 - Healthcare infor...

4/25/11

She is verbally abusive to the staff, and does not make it clear what her agenda is. I listened to her talk about her sons, her grandsons, her daughter in law, and a whole host of off-topic subjects. We have many reasons to cut ties with this patient, and today was the last straw.

Please send her our generic discharge letter stating that we will no longer be her primary care office and that she can seek care elsewhere.

WHH

4/22/11 Left message on patient's answering machine to return call.

4/25/11 at 1:51 pm patient returned my call. I was going over her x rays with her and she wanted to know "why the hell that Dr Harris only ordered knee films not hip films. I tried to explain and she became very upset "why doesn't he listen to me. "I told him that I couldn't even lay on my H-P at times. "I feel like this is the same crap that happens to me with my heart" He didn't listen!! She was raising her voice to the point that I held the phone out from my ear! She asked about her records from her last Dr regarding her hip, did you get them I said no. again Tried

to explain that we had to fax a records request to them. "The hell you do I talked to them, they said that all you had to do was call and they would fax them right over. She gave the phone number to Nesha to call not fax!

Again I tried to explain. She was screaming at me "what's wrong with this office" I asked her to hold while I get Nesha. to Explain as well.

After Nesha was finished I picked up the phone to talk to 4 - Hea... about sending her for a hip xray she replies "I get you, Nesha , Christy , and now he has you talked to me again.

Then she said to hell with it I will take care of this myself once and for all.

04/25/11 after Teresa tried to explain to 4 - He... e. Teresa then put 4 - Heal... on hold thinking that I could explain better since I was the one who called the other office for there fax number. 4 - Heal... screamed at me. I explained to her that's how doctor's office work. They require a written authorization. She said no "I told you that you need to call them and get the records" I told her I did what I was told and she raised her voice and said "No you didn't." I really didn't know what to say. She just kept yelling at me. I said I was sorry for the inconviance Christy took over and said 4 - Healt... I am putting you on hold so that you could talk to Dr Harris.

Nesha

TRA | Medical Imaging
ON LILLY
formerly Northwest Radiology Group

500 Lilly Road | Olympia, WA 98506 | tel [360] 413-8383 | fax [360] 413-8323

Imaging Report

DATE OF SERVICE: 04-21-11

PATIENT NAME:
4 - Healthcare information re...

REFERRING PHYSICIAN:
WILLIAM K HARRIS, MD

ACCOUNT NUMBER:
739329

6981 LITTLEROCK RD SW STE 101

DATE OF BIRTH/SEX:
4 - Healthc... /F

OLYMPIA, WA 98512-

EXAM: LEFT KNEE X-RAY SERIES

HISTORY:
75-year-old woman with lefl knee pain for weeks. Pain with walking.

TECHNIQUE:
Two views.

COMPARISON:
None.

FINDINGS:
No bony fracture or dislocation. There is fairly significant degenerative spurring at the patellofemoral joint with additional spurring at the medial and lateral femoral tibial compartment. There is a small joint effusion. There is spiking of the tibial spines.

On these nonweightbearing views, I don't see see any significant joint space narrowing of the femoral-tibial compartment but there is fairly significant joint space narrowing along the patellofemoral joint.

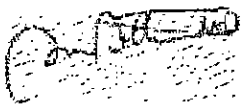
No osseous destructive lesion or periarticular calcification.

IMPRESSION:
1. No acute bony abnormality.
2. Tricompartmental osteoarthritis, worse at the patellofemoral joint.
3. Small joint effusion.

Thank you for this referral. For consultation with the radiologist, please call 360-413-8383.

- TAKE INDOCIN FOR PAIN
→ P.T. FOR KNEE PAIN
- IF NOT STRONGER PAIN MEDS?

WKH pc
kmom pc



RANDALL PATTEN, MD

Oh
Ron

000040

W. Kirk Harris, MD
Littlerock Family Medicine

6981 Littlerock Rd SW #101
Tumwater, WA 98512

Tel: 360-943-3633
Fax: 360-528-4643

04/20/11

4 - Healthcare inf...

75yo

03/11 CMP WNL. WBC 8, HCT 43, PLT 247.
Patient is not having gout on increased dose Allopurinol 300mg qd.
She has had worsening left knee pain for the past three weeks. This is well localized into the joint but radiates up into the thigh such that she is limping with ambulation. Pt denies any trauma, injuries, or accidents.
Exam: 136/84
Knee exam: No bruising, discoloration, or deformity. Nontender/full ROM. Ligament testing shows no significant/abnormal laxity. No joint line nor patella manipulation tenderness. There is some generalize swelling to the left knee. No DVT is palpated in the inner thigh. Negative Homan's sign. She does not have pretibial edema.

Impression:	DJD Left Knee 715.16	C-spine DDD 722.4
	Type 2 Diabetes 250.00	Hypertension 401.1

Plan: Start Percocet 5mg/325mg tid prn severe knee pain. we will send her for knee films to evaluate extent of DJD. Precautions given for calling/returning w/ positive feedback.

jrp

Harris, MD

Littlerock Family Medi[illegible]
6981 Littlerock Rd SW Ste 101
Tumwater, WA 98512

PACLAB NETWORK LABORATORIES

CLIENT SERVICES (800) 874-2969 FAX (360) 456-2740

For additional diagnostic criteria, see our Test Directory at www.paml.com

PATIENT NAME	PATIENT ID	DOB	SEX	AGE	PT. PHONE NO.	PT.LAB NO.	
4 - Healthcare information readil...	02101936JT	4 - Healthcare infor...	F	75 Y	4 - Healthcare infor...		
PHYSICIAN	**COLLECT DATE & TIME**	**DATE OF SERVICE**	**REQUISITION NO.**	**STATUS**	**PAGE**		
HARRIS MD, KIRK	03/16/2011 15:40	03/16/2011	1000234	Final	1		

Comments/CC:W2335474:CMPAC - Patient Not Fasting; AHEMP2, ATDIF2, CMPAC- SPH

Diagnostic Procedure	In Range	Out of Range		Units	Reference Range	Site Code
Comprehensive Metabolic Panel						
Sodium	142			mmol/L	135-145	31
Potassium	3.6			mmol/L	3.5-5.3	31
Chloride		96	L	mmol/L	98-109	31
CO2		36	H	mmol/L	22-30	31
Glucose	78			mg/dL	65-99	31
Pregnant normals 65 to 94 mg/dL						
BUN	16			mg/dL	7-23	31
Creatinine		1.38	H	mg/dL	0.60-1.20	31
Calcium	9.9			mg/dL	8.5-10.5	31
Protein, Total	7.6			g/dL	6.3-8.0	31
Albumin	4.0			g/dL	3.3-4.8	31
Bilirubin, Total	1.1			mg/dL	0.1-1.5	31
Alkaline Phosphatase	71			U/L	38-110	31
AST	28			U/L	5-40	31
ALT	20			U/L	5-50	31
Hemogram with Plt						
White Blood Cells	8.4			K/uL	4.0-11.0	31
Red Blood Cells	4.64			M/uL	3.80-5.20	31
Hemoglobin	14.4			g/dL	11.6-15.5	31
Hematocrit	42.8			%	35.0-46.0	31
MCV	92.3			fL	80.0-96.0	31
MCH	31.0			pg	27.0-34.0	31
MCHC	33.6			g/dL	32.0-35.5	31
RDW	14.1			%	11.0-14.5	31
Platelets	247			K/uL	150-400	31
Differential						
Differential Type	SEE BELOW					31
Manual Diff: No						
Neutrophils	60.0			%		31
Lymphocytes	32.0			%		31
Monocytes	5.0			%		31
Eosinophils	3.0			%		31
Basophils	0.0			%		31
Nucleated RBCs	0.0			/100 WBCs		31
Neutrophils, Absolute	5.00			K/uL	2.0-7.3	31
Lymphocytes, Absolute	2.70			K/uL	1.0-3.4	31
Monocytes, Absolute	0.40			K/uL	0.0-0.8	31
Eosinophils, Absolute	0.30			K/uL	0.0-0.5	31
Basophils, Absolute	0.00			K/uL	0.0-0.1	31

WK Hpc RD

Performing Labs

31 Providence St Peter Hosp, 413 Lilly Rd NE, Olympia, WA 98506

End of Report

VNB

W. Kirk Harris, MD
Littlerock Family Medicine

6981 Littlerock Rd SW #101
Tumwater, WA 98512

Tel: 360-943-3633
Fax: 360-528-4643

03/16/11

4 - Healthcare inf...

75yo

02/11 CMP WNL except Potassium 3.0 and Creatinine 1.3. Patient was increased to Potassium 10meq bid with instructions to recheck blood work in one month.
Swelling is well controlled on Lasix 40mg qam. Blood pressures is fairly well controlled with Metoprolol 20mg bid.
Patient saw podiatrist Dr. Stone on 03/09/11 for significant pain from gout. At that time she had some improvement on increased dose Allopurinol 200mg qd. We spoke on the phone and agreed to increase further to 300mg qd and to add Colchicine 0.6mg qd-bid.
The patient is happy to report that her gout pain is significantly improved on increased dose gout medication.
She is still bothered by some insomnia and secondary fatigue saying that she simply has not recovered from her open heart surgery in January. She does not have the drive to walk for exercise yet. She still feels like her left leg is a bit unsteady. The patient c/o no cold, cough, fever, chills, or sore throat. There have been no interruptions to sleeping, eating nor activity patterns. Pt c/o no itchy, runny, eyes & nose w/ sneezing. Pt denies any chest pain, shortness of breath, palpitations, racing heart, and skipped beats. Complete Review of Systems otherwise minimized.
Exam: 140/90 199# Room Air Pulse Ox 96%
Cardiopulmonary exam benign. No LE edema. Right foot shows continued third toe tophus and great toe mild redness and swelling without significant pain or heat.

Impression:		
	Right Foot Gout 274.9	Insomnia 780.52
	Type 2 Diabetes 250.00	C-spine DDD 722.4
	CHOL 272.0	Hypertension 401.1
	DJD Knee 715.16	Gastritis 535.50

Plan: Increase Allopurinol to 300mg qd and continue Colchicine 0.6mg bid. Continue other meds unchanged.
Recheck CBC and CMP to further evaluated Potassium level on increased dose and the possibility of anemia contributing to ongoing fatigue/left leg unsteadiness. Precautions given for calling/returning w/ positive feedback. Further evaluation / treatment as indicated. RTC prn.

jrp

Harris, MD

CASCADE FOOT & ANKLE CLINIC

Loren B. Stone, JR., D.P.M.

4 - Healthcare information r... **DOB:** 4 - Healthcare in... **03/09/2011**

Subjective: The patient is a 75-year-old female. She presents with considerable pain to the right great toe from gout. She started having gout problems, again, about a week or more ago. She has had a very large area of tophi to the dorsal aspect of the third toe right foot just proximal to the nail plate. She states this area is not painful. It is the right great toe that has been very painful in the past few days. She has considerable redness to the right great toe and more to the distal one half but she appears swollen around the first metatarsal phalangeal joint. She states this whole area has been quite painful to walk on the past few days. She has been to her physician, Dr. Harris in Tumwater and he started her on allopurinol 100 mg tablets daily. However, he increased her allopurinol to two 100 tablets daily a few days ago. But she states this has gotten worse as far as the pain, redness, swelling. It is more difficult to walk on the right foot. She states she is a diabetic and takes oral medication for this.

Assessment: Diabetic type II. Probable acute gout right foot around the first metatarsal phalangeal joint and great toe and possibly across the other metatarsal phalangeal joints as well. Gouty tophi to the end of the third toe right foot.

Plan: I examined both feet. I discussed the condition of the right foot with her. I called and discussed her condition with Dr. Harris. He suggested to increase her to 3-100 mg tablets of allopurinol daily and we discussed the use of colchicine 0.6-mg tablets and to place her on 7 days of the medication, taking it one tablet b.i.d.. Also the patient is to get an appointment to see Dr. Harris next week. I told her that I would be out of town for two weeks but if she wanted to come back in about 3 weeks we could possibly address the gouty tophus in the third toe at a later time but that she needed to get her acute gout condition under control.

Loren B. Stone Jr., DPM

CC Kirk W. Harris, MD
Littlerock Family Medicine
Tumwater, Wa.

Littlerock Family Medicine
6981 Littlerock Rd SW Ste 101
Tumwater, WA 98512

PACLAB NETWORK LABORATORIES

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For additional diagnostic criteria, see our Test Directory at www.paml.com

PATIENT NAME	PATIENT ID	DOB	SEX	AGE	PT. PHONE NO.	PT.LAB NO.	
4 - Healthcare information readil...	02101936JT	4 - Healthcare info...	F	75 Y	4 - Healthcare inform...		
PHYSICIAN	**COLLECT DATE & TIME**	**DATE OF SERVICE**			**REQUISITION NO.**	**STATUS**	**PAGE**
HARRIS MD, KIRK	**02/28/2011 12:04**	**02/28/2011**			**1000162**	**Final**	**1**

Comments/CC: M2234407:CMPAC - Patient Not Fasting; CMPAC- SPH

Diagnostic Procedure	In Range	Out of Range		Units	Reference Range	Site Code
Comprehensive Metabolic Panel						
Sodium	145			mmol/L	135-145	31
Potassium		3.0	L	mmol/L	3.5-5.3	31
Chloride		96	L	mmol/L	98-109	31
CO2		38	H	mmol/L	22-30	31
Glucose	81			mg/dL	65-99	31
Pregnant normals 65 to 94 mg/dL						
BUN	18			mg/dL	7-23	31
Creatinine		1.31	H	mg/dL	0.60-1.20	31
Calcium	9.5			mg/dL	8.5-10.5	31
Protein, Total	7.1			g/dL	6.3-8.0	31
Albumin	3.7			g/dL	3.3-4.8	31
Bilirubin, Total	0.9			mg/dL	0.1-1.5	31
Alkaline Phosphatase	66			U/L	38-110	31
AST	25			U/L	5-40	31
ALT	17			U/L	5-50	31

Performing Labs

31 Providence St Peter Hosp, 413 Lilly Rd NE, Olympia, WA 98506

End of Report

She should increase her potassium dose. She is taking K-Dur 10meq once daily.

Please have her increase this to K-Dur 10meq twice daily, and we'll recheck her lab in 1 month. Thanks!

WKHpc Lmontrc 3/3/11

Lmontrc 3/3/11

Pt. notified — Ly

W. Kirk Harris, MD
Littlerock Family Medicine

6981 Littlerock Rd SW #101
Tumwater, WA 98512

Tel: 360-943-3633
Fax: 360-528-4643

2/28/2011

4 - Healthcare info...

75yo

Pt started Allopurinol 100mg bid but has not had much improvement in her foot pain. This discomfort radiates from ankle through mid-foot to distal foot including the toes. Pt denies any trauma, injuries, or accidents.
Pt complains of ringworm rash under the breasts and would like something stronger than OTC cream.
Pt is upset because she feels that her sons are unappreciative in that they forgot her birthday. She discusses, at length, the troubles that she has had with her boys through the years.
She is tired but only describes some discomfort across the back. Pt denies any chest pain, shortness of breath, palpitations, racing heart, and skipped beats.
Exam: 122/62
Foot exam is completely unremarkable with no redness, heat, pain nor swelling elicited/detected. She has strong pulses in the feet. Cardiopulmonary exam benign. No LE edema. She had a blowing early systolic murmur.

Impression:		
	Right foot Gout 274.9	Insomnia 780.52
	Tension headaches 307.81	Type II diabetes 250.00
	Left shoulder DJD 715.11	C-spine DDD 722.4
	CHOL 272.0	Hypertension 401.1
	DJD knee 715.16	Gastritis 535.50
	Anxiety 300.00	Depression 311
	Breast tinea 110.9	Adjustment reaction 309.9

Plan: Double Allopurinol to 200mg bid for gout.
Start Lotrisone cream to breast tinea bid prn.
Will check CMP on current medicines.
Will refer pt to podiatrist for further evaluation of her persistent foot pain.
Prescriptions were sent to diabetes supply companies for test strips both on 1/13/2011 and 2/18/2011.
Precautions given for calling/returning w/ positive feedback. Pt will be seeing cardiologist, Dr. Brennan, in 2d for interval assessment. Further evaluation / treatment as indicated. RTC prn.

LKM

Harris MD

W. Kirk Harris, MD
Littlerock Family Medicine

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Tumwater, WA 98512

Tel: 360-943-3633
Fax: 360-528-4643

915-7733

01/26/11

4 - Healthcare inf...

74yo

01/11 CMP WNL except Potassium 3.3. Glucose was 130. WBC 8, HCT 40, PLT 244. Patient was called and told that she was low on Potassium in 12/10 and was supplemented in the hospital. She has to continue on Lasix for leg swelling but is currently not taking a Potassium supplement pill along with it. She was given a Rx for Potassium 10meq qd to be taken as long as she is on the Lasix daily.

She is taking Dalmane 15mg qhs for insomnia but complains that it has a slow onset. She has been on other sleep meds and wishes to continue on this one.

For the past ten days that patient has had right foot swelling and discomfort. This is limited to the ankle and foot. Pt denies any trauma, injuries, or accidents. She has a constant, right, third, distal toe tophus but is not currently adhering to a strict low-purine diet nor is she on gout preventive medication. She may not take Indocin because of the renal and cardiac side effects.

Patient is now two months status post aortic valve replacement surgery for aortic stenosis and reports that she has no chest pain and no SOB/DOE. She is attending cardiac rehab classes and is building up her exertional tolerance nicely. She has followed up with the cardiologist and has received a good report.

Pt c/o two-sided, mildly-moderately severe, constant headaches which radiate into the neck and have no associated vision changes and vomiting. These are intermittent and have not responded recently to OTC meds.

Exam: 130/68

Cardiopulmonary exam benign. She has trace LE pitting edema with the right foot generally being somewhat larger than the left. Negative Homan's sign. No DVT palpated in either calf There is indeed a tophus which is bright red and the shape of an M&M on the upper tip of her right third distal toe. She has a well-healed, chest-wall sternotomy scar. No signs of infection (redness, heat, pain, swelling, drainage). Palpation recreates some general aching chest discomfort on both mid-clavicular lines.

Impression:	Right Foot Gout 274.9	Insomnia 780.52
	Tension Headaches 307.81	Type 2 Diabetes 250.00
	Left Shoulder DJD 715.11	C-spine DDD 722.4
	CHOL 272.0	Hypertension 401.1
	DJD Knee 715.16	Gastritis 535.50
	Anxiety 300.00	Depression 311

Plan: Start Allopurinol 100mg qd-bid for gout. This does not appear to be an acute attack so we will simply ease into anti-gout treatment with conservative Allopurinol. We will avoid Colchicine or NSAIDs now. Suggested Tylenol 500mg qid for pain.

At last check in 09/10 her A1C 5.7. We will plan on recheck in 03/11 along with Potassium redraw on supplementation. Precautions given for calling/returning w/ positive feedback. Further evaluation / treatment as indicated. RTC prn.

jrp 1/28/11 haven't gotten meds yet. will call if there are any concerns — JBMAS Amin, MD

4 - Healthcare inform...

1/6/11

She was low on potassium a month ago and was supplemented in the hospital.

She has to continue on lasix for leg swelling, but is currently not taking a potassium supplement pill along with it.

This shows that she is low on her potassium (probably from the lasix), and so she should start chronic K-Dur 10meq qd as long as she is on the lasix daily.

Blood sugar is slightly high — we'll check it again when she is in.

1/6/11
Cmonroe

WKHpc

1/6/11 pt notified
R. Gin SMA

Littlerock Family Medicine
6981 Littlerock Rd SW Ste 101
Tumwater, WA 98512

PACLAB NETWORK LABORATORIES

CLIENT SERVICES (800) 874-2969 FAX (360) 456-2740

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PATIENT NAME	PATIENT ID	DOB	SEX	AGE	PT. PHONE NO.	PT.LAB NO.	
4 - Healthcare information readil...	02101938JT	4 - Healthcare info...	F	72 Y	4 - Healthcare informati...		
PHYSICIAN	**COLLECT DATE & TIME**	**DATE OF SERVICE**	**REQUISITION NO.**			**STATUS**	**PAGE**
HARRIS MD, KIRK	**01/05/2011 14:22**	**01/05/2011**	**1000016**			Final	1

Comments/CC:W2171197:CMPAC - Patient Not Fasting; CMPAC- Sample received unspun, may compromise results.; AHEMP2, ATDIF2, CMPAC- SPH

Diagnostic Procedure	In Range	Out of Range		Units	Reference Range	Site Code
Comprehensive Metabolic Panel						
Sodium	141			mmol/L	135-145	31
Potassium		3.3	L	mmol/L	3.5-5.3	31
Chloride		93	L	mmol/L	98-109	31
CO2		37	H	mmol/L	22-30	31
Glucose		130	H	mg/dL	65-99	31
Pregnant normals 65 to 94 mg/dL						
BUN	20			mg/dL	7-23	31
Creatinine		1.21	H	mg/dL	0.60-1.20	31
Calcium	8.7			mg/dL	8.5-10.5	31
Protein, Total	7.2			g/dL	6.3-8.0	31
Albumin	3.8			g/dL	3.3-4.8	31
Bilirubin, Total	1.2			mg/dL	0.1-1.5	31
Alkaline Phosphatase	66			U/L	38-110	31
AST	27			U/L	5-40	31
ALT	21			U/L	5-50	31
Hemogram with Pit						
White Blood Cells	7.6			K/uL	4.0-11.0	31
Red Biood Cells	4.22			M/uL	3.80-5.20	31
Hemoglobin	13.6			g/dL	11.6-15.5	31
Hematocrit	40.2			%	35.0-46.0	31
MCV	95.1			fL	80.0-96.0	31
MCH	32.1			pg	27.0-34.0	31
MCHC	33.8			g/dL	32.0-35.5	31
RDW	13.0			%	11.0-14.5	31
Platelets	244			K/uL	150-400	31
Differential						
Differential Type	SEE BELOW					31
Manual Diff: No						
Neutrophils	65.0			%		31
Lymphocytes	27.0			%		31
Monocytes	6.0			%		31
Eosinophils	2.0			%		31
Basophils	0.0			%		31
Nucleated RBCs	0.0			/100 WBCs		31
Neutrophils, Absolute	4.90			K/uL	2.0-7.3	31
Lymphocytes, Absolute	2.10			K/uL	1.0-3.4	31
Monocytes, Absolute	0.50			K/uL	0.0-0.8	31
Eosinophils, Absolute	0.20			K/uL	0.0-0.5	31
Basophils, Absolute	0.00			K/uL	0.0-0.1	31

WK Hpc
1/6/11 Lmontec 0132

Performing Labs

31 Providence St Peter Hosp, 413 Lilly Rd NE, Olympia, WA 98506

End of Report

1/12/11 pt notified R. Gm Sima

4 - Healthcare information re...	DOB 4 - Healthcare infor...	F	01/06/2011 08:10	Littlerock Family Medicine	D9021

W. Kirk Harris, MD
Littlerock Family Medicine

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Tumwater, WA 98512

Tel: 360-943-3633
Fax: 360-528-4643

01/05/11

4 - Healthcare info...

74yo

09/10 CMP WNL except Glucose 121. AIC 5.7. WBC 9, HCT 45, PLT 178. UA showed large leukocyte esterase and 4+ WBCs. TSH WNL. She was called and encouraged to continue antibiotics.

Patient saw cardiologist, Dr. Brennan, on 10/29/10 regarding chest pressure and tightness with SOB. He gave her nitroglycerin and suggested angiogram to evaluate for ML BMP WNL except glucose 133 and Creatinine 1.5. Chest X-ray showed scaring from prior granulomatous change. Nuclear Stress Test was unremarkable.

11/02/10 the patient was admitted to Providence Hospital regarding consultation regarding progressive chest pressure, fatigue and DOE. Chest X-ray showed granuloma and pleural fibrosis with no acute cardiopulmonary process.

Echocardiogram showed a stenotic aortic valve with less than 1cm squared aortic valve area. WBC 13, HCT 32, PLT 83. CMP WNL. Glucose range 122-186. Patient underwent aortic valve replacement surgery through an upper-mini sternotomy incision and recovered nicely. Post operative chest X-ray was WNL. She was discharged from Providence Hospital on 11/13/10 and followed up with cardiothoracic surgeon, Dr. Quinton, on 11/15/10. She was doing well at that time after her post opt atrial fibrillation converted to normal sinus rhythm with medical therapy. EKG confirmed NSR.

The patient then had the month of December with Providence South Home Health checking her wound and assisting with her mobility and recovery.

Patient is doing well on aspirin 325mg qd, Vicodin 5mg qhs prn, Metoprolol 25mg bid, Simvastatin 20mg qd, Lasix 40mg qam, Prozac 40mg qd, Metformin 500mg bid and Lorazepam prn. Her Amiodarone and Potassium were discontinued a month ago. She has plans to follow up with the cardiologist in one to two months.

Patient is happy to report that she feels very energetic, has not SOB, there is no DOE, fatigue or depression, and she is ready to dance again. She is very pleased with the outcome of her surgery but still has some mixed feelings about the delay in the diagnosis regarding her aortic stenosis. She is eating well, sleeping well, voiding and stooling normally with minimal pain. She knows that if she does not take Lasix she will get leg swelling.

Exam: 18 69 148/82 188#

Cardiopulmonary exam benign. No LE edema. She has a well-healed, upper-sternotomy scar. No signs of infection (redness, heat, pain, swelling, drainage). Pulses are strong with no lower extremity edema.

Impression: Status Post Aortic Valve Replacement Surgery for Aortic Stenosis

Type 2 Diabetes 250.00	Left Shoulder DJD 715.11
C-Spine DDD 722.4	CHOL 272.0
Hypertension 401.1	Gout 274.9
DJD Knee 715.16	Gastritis 535.50
Anxiety 300.00	Insomnia 780.52
Depression 311	

Plan: Continue current medicines unchanged. Refilled Simvastatin and Lasix and sent her for interval CMP and CBC.

Strongly encouraged her to begin a cardiac rehab program now that she has fully recovered with her surgery. She will follow up with cardiologist, Dr. Brennan, on 03/22/11.

Consent form signed and flu shot administered with no reaction. Precautions given for calling/returning w/ positive feedback. Further evaluation / treatment as indicated. RTC prn.

1/11 flu care pt feeling very well today still dancing
asking for a talking BS machine. Gave pt for free Talking Diabetic meter Voice point

Harris, MD

Cardiology Associates
500 Lilly Rd NE Olympia, WA 98506
(360) 413-8525

TEST/PROCEDURES

ECG
BRENNAN, WILLIAM P M.D.
12/01/2010

4 - Healthcare information readil...
143-249-508
4 - Healthcare i...

INDICATIONS:
Chest Pressure/Tightness
DM Non-Insulin Controlled
Hypertension Controlled
Hypercholesterolemia

RESTING ECG: Normal sinus rhythm. Normal ECG.

[Created: WILLIAM P BRENNAN M.D. on 12/01/2010 at 12:34 PM]
[Transcribed: JESSICA JOHNSON_MA on 12/01/2010 at 01:04 PM]
[Approved: PATRICIA BORN_RN for BRENNAN, WILLIAM P M.D. on 12/28/2010 at 02:58:32 PM]
[Finalized: 12/28/2010 at 02:58:32 PM]

cc.
W Kirk Harris MD|6981 Littlerock Road, #101|Tumwater, WA 98512

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JAN - 5 2011

WKH

CLINICAL NOTES

PROGRESS NOTE
BRENNAN, WILLIAM P M.D.
12/01/2010

4 - Healthcare information readily...
143-249-508
4 - Healthcare i...

REFERRING PHYSICIAN: W Kirk Harris MD

ACTIVE PROBLEMS:
1. Rule Out Coronary Artery Disease Characterized By;
   a. Class-3 limiting effort angina and dyspnea;
   b. Positive Myoview with ST segment depression and chest pain with Lexiscan effusion images pending;
   c. Resting anterolateral ST segment depression.
2. Diabetes Mellitus, Type-2.
3. Hypertension.
4. Hypercholesterolemia.

REASON FOR VISIT:
CAD-Art Bypass Graft
DM Non-Insulin Controlled
Hypertension Controlled
Hypercholesterolemia

HPI:
4 - Heal... returns today post bypass surgery. She presented with Class III angina. Her angiography, demonstrated aortic stenosis with a valve area of 0.6, a gradient of 55. She underwent aortic valve replacement with minimally invasive sternotomy and a Hancock 2 bioprosthesis 21.0 mm by Dr. Quinton 11/10. She had some early postoperative atrial fibrillation but then converted and eventually was discharged to home after a few days. She has done well since she has been home. She has some chest soreness but no anginal pain similar to what she had prior to her surgery. She did not require any bypasses at the time of surgery. She denies orthopnea, PND, peripheral edema.

CURRENT MEDICATIONS:
FLUOXETINE CAP 40mg 1 CAP PO QDAY in the morning
METFORMIN TAB 500mg 1 TAB PO BID with morning and evening meals
SIMVASTATIN TAB 20mg 1 TAB PO QDAY in the evening
ASA 325mg 1 TAB PO QDAY
NITROGLYCERIN SUBLINGUAL TAB 0.4mg Place 1 TAB SL at the 1st sign of an attack - may repeat every 5 min until relief up to a maximum of 3 doses
METOPROLOL TARTRATE TAB 25mg 1 TAB PO BID
PEPCID TAB 20mg 1 TAB PO BID
AMIODARONE TAB 200mg 1 TAB PO BID
FUROSEMIDE TAB 40mg 1 TAB PO QDAY
POTASSIUM CHLORIDE SR CAP 10meq 1 CAP QDAY

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DEC 08 2010

Allergies and Intolerances-- X-NKDA

REVIEW OF SYSTEMS: Pt says she is doing great - BS WKH 12/9/10

General- The patient reports fatigue, recent weight loss and sweats, but denies fevers or chills. Skin- No rashes. HEENT- The patient reports dizziness and hearing problems, but denies headaches or vision problems. Lungs- The patient reports orthopnea and DOE, but denies PND or wheezing. Heart- The patient reports chest pressure, heart murmurs and palpitations, but denies chest pain or heart murmur. GI- The patient reports loss of appetite, but denies bleeding from bowels, constipation, diarrhea, heartburn or indigestion. GU- No burning with urination, frequent urination or incontinence. Extremities- The patient reports arthritis, but denies ankle swelling or difficulty walking. Neuro- The patient reports difficulty with coordination and forgetfulness, but denies numbness or seizures. Psych- The patient reports anxiety and depression.

HABITS:
Tobacco- Never, Alcohol- Never

PHYSICAL EXAMINATION:
VITALS- BP 132/68 Pulse 64 (Initial RA Sitting Large Cuff), Weight 189 lbs, Height 63 inches, Bsa 1.95 m2, Bmi 33.48 kg/m2

CONSTITUTIONAL- The patient is well-appearing and is in no acute distress.
NECK- No significant JVD. No adenopathy.
CHEST- Grossly normal.
LUNGS- Clear to auscultation.
HEART
RHYTHM- Rhythm is regular.
PALPATION- PMI is within the MCL.
VALVES- S1 and S2 are normal.
GALLOPS- There is no S3 or S4.
AORTIC VALVE- Normal.
MITRAL VALVE- Normal.
ABDOMEN- Benign without hepatomegaly or splenomegaly.
EXTREMITIES- No clubbing, cyanosis or edema.
NEURO- Grossly intact.
PSYCH- Nonfocal and oriented to time and place without mood disturbance.

LIPID PROFILES:

	02/19/2009	05/27/2010	09/21/2010
CHOLESTEROL	-	-	-
HDL	-	-	-
LDL	-	-	-
SGOT	22	25	25
SGPT	19	24	25
TRIGLYCERIDES	-	-	-

IMPRESSION:
1. Status post aortic valve replacement, Dr. Quinton, 21.0-mm Hancock bioprosthesis, 11/10/10.
2. Organic heart disease prebypass surgery characterized by;
a. Angiography demonstrating peak gradient of 55, a valve area of 0.6 cm2, normal coronary arteries, ejection fraction 68%.
3. Other problems as above.

RECOMMENDATION:
The patient is doing well. We will get her enrolled in cardiac rehab. Otherwise, as listed.

PLAN:
1. Change to AMIODARONE TAB 200mg 1 TAB PO QDAY.
2. Followup Appointment in Olympia in 2 months.
3. Enroll in phase 2 rehab.

[Created: WILLIAM P BRENNAN M.D. on 12/01/2010 at 12:34 PM]
[Transcribed: CC on 12/02/2010 at 08:57 AM]
[Approved: PATRICIA BORN_RN for BRENNAN, WILLIAM P M.D. on 12/03/2010 at 11:11:15 AM]
[Finalized: 12/03/2010 at 11:11:15 AM]

cc.
W Kirk Harris MD|6981 Littlerock Road, #101|Tumwater, WA 98512

Olympia Cardiac Surgery, Inc., P.S.

CARDIAC, THORACIC, AND VASCULAR SURGERY

525 Lilly Rd. NE Suite 200 Olympia WA 98506
(360) 493-4510

November 15, 2010

Dr. W. Kirk Harris
6981 Littlerock Road #101
Tumwater, WA 98512

Re: 4 - Healthcare information readil...

Dear Dr. Harris:

4 - Healthcare information readily ..., 74, was discharged from St. Peter Hospital on November 13, 2010 following an aortic valve replacement through an upper mini sternotomy using a 21-MM MEDTRONIC Hancock II T505 cinch porcine bioprosthesis on November 10th, 2010. She was in CICU for one day then transferred to PCU for the remainder of her care.

Her postoperative course was complicated by atrial fibrillation which converted to normal sinus rhythm with medical therapy. On discharge her sternum is stable and her incisions are healing well. I will see her in my office in four weeks for a follow up visit. Please see attached discharge medication sheet for medications.

When discharged from St. Peter Hospital her HCT was 29.0.

You will receive a copy of her operative report and the discharge summary under separate cover from St. Peter Hospital. Thank you for the opportunity to participate in the care of Mrs. Tuitele.

Sincerely,

Ronald R. Quinton, M.D., F.A.C.S.

RQ/da

RONALD R. QUINTON, M.D., F.A.C.S.
Diplomate, American Board of Surgery
Diplomate, American Board of Thoracic Surgery

MARINA V. BERNDT, P.A.C.

LUIS F. SANTAMARINA, M.D.
Diplomate, American Board of Surgery
Diplomate, American Board of Thoracic Surgery

PROVIDENCE ST. PETER HOSPITAL
Olympia, Washington

(This information may be protected by Federal and/or State Law prohibiting further disclosure.)

Admit Date: 11/10/2010
Discharge Date: 11/13/2010

DATE OF ADMISSION: 11/10/2010.

DATE OF DISCHARGE: 11/13/2010.

HISTORY OF PRESENT ILLNESS AND COURSE: The patient is a 74-year-old Scottish female admitted with symptomatic critical aortic stenosis. She was taken to the operating room on the day of admission, and underwent an aortic valve replacement through a minimally invasive upper mini sternotomy incision. Her valve was replaced with a Medtronic Hancock II Ultra 21 mm stented bioprosthetic. Postoperatively, the patient has done well. She did develop atrial fibrillation which converted to sinus rhythm with medical therapy. At the time of discharge, she is ambulating 360 feet and able to get out of the bed and chair without problems. Her incisions are healing without evidence of infection or drainage. Discharge weight is 91.5 kg with preoperative weight of 85 kg. Last hematocrit was 29.

FINAL DIAGNOSES:
1. Aortic stenosis.
2. Atrial fibrillation postoperatively.
3. Hypertension.
4. Hypercholesterolemia.
5. Non-insulin dependent diabetes mellitus.
6. Chronic kidney disease stage 3.

PROCEDURES PERFORMED: Minimally invasive upper mini sternotomy with aortic valve replacement.

DISCHARGE MEDICATIONS: Enteric-coated aspirin 325 mg a day, Vicodin 5/325 mg p.o. q. 4 hours p.r.n. pain. Metoprolol 25 mg p.o. b.i.d. for 4 weeks, famotidine 20 mg p.o. b.i.d. for 2 weeks, simvastatin 40 mg q.p.m., amiodarone 200 mg p.o. b.i.d. for 4 weeks, furosemide 40 mg a day for 4 weeks, potassium chloride 10 mEq a day for 4 weeks, fluoxetine 40 mg daily, metformin 500 mg p.o. b.i.d., lorazepam as used preoperatively. Hydrochlorothiazide 25 mg, the patient to start this when her Lasix is done in 1 month.

ACTIVITIES: Patient may participate in cardiac rehab. The patient not to lift greater than 10 pounds for 6 weeks. Patient not to drive for 3 weeks.

DIET: No added salt, low salt, low cholesterol, low fat, carb controlled diet.

FOLLOWUP: The patient to see Dr. Brennan in approximately 2 weeks. Patient to see Dr. Quinton in 4 weeks.

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NOV 22 2010
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Admit Date: 11/10/2010

DATE OF OPERATION: 11/10/2010

DATE OF OPERATION: 11/10/2010

PREOPERATIVE DIAGNOSIS: Critical aortic stenosis.

POSTOPERATIVE DIAGNOSIS: Critical aortic stenosis.

OPERATION PERFORMED: Aortic valve replacement through an upper mini sternotomy incision.

SURGEON: Ronald Quinton, MD

ASSISTANT: Ken Eder, RNFA

ANESTHESIA: General endotracheal anesthesia with extracorporeal circulation.

ANESTHESIOLOGIST: Telfer Griffith, MD

PERFUSIONIST: Mr. Wilken

SPONGE AND NEEDLE COUNTS: Reported correct.

DRAINS: 2 Blake drains and a Foley catheter.

FINDINGS: Only the aorta and aortic valve could be visualized. The aorta was somewhat small in diameter but otherwise normal quality. Aortic valve was tricuspid. It had calcific stenosis. Aortic valves placed with a Medtronic Hancock II Ultra 21 mm porcine bioprosthetic stented valve. Postprocedure TEE demonstrated good prosthetic valve function.

SURGICAL PROCEDURE: The patient was brought the operating room, placed in a supine position. After adequate general anesthesia was obtained, the patient was prepped and draped in the usual sterile fashion. A minimally invasive upper mini sternotomy incision was made. The sternum was divided down to the third intercostal space then J'd to the right. The patient was heparinized. The sternum was spread and the mediastinal fat divided. The pericardium was opened and suspended. Heart was cannulated with an aortic inflow cannula through the distal ascending aorta and 2-stage venous uptake cannula through the right atrial appendage. The patient was placed on normothermic extracorporeal circulation. An antegrade cardioplegic catheter was placed. Aortic crossclamp was then placed. The heart was given cold blood potassium cardioplegic solution, first antegrade and then directly into the coronary ostia after we opened the aorta. The left ventricular sump was placed to the right superior pulmonary vein. The aorta was opened transversely at the sinotubular junction. The aorta was quite small at the sinotubular junction. I had to extend the incision down into the noncoronary sinus in a J fashion to be able to get a sizer in. The

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(This information may be protected by Federal and/or State Law prohibiting further disclosure.)

aortic valve was excised and the annulus decalcified. The new valve was seated using interrupted horizontal mattress sutures of 2-0 Ethibond with pledgets on the ventricular side of the annulus. The aortotomy was then closed with running 4-0 Prolene suture in a double layer. The patient was placed in Trendelenburg position. The heart was given a warm shot of cardioplegic solution and warm blood. There was some leakage around the closure part of the noncoronary sinus. This was reinforced with pledgeted 4-0 sutures. At completion of the cardioplegia, warm blood, the cross-clamp was removed. Heart came back in a slow junctional rhythm. We did place a ventricular wire and paced for part of the case. The wire was removed at the end of the case as she was in her own sinus rhythm at 75. The patient given protamine. After adequate hemostasis obtained, a Blake drain was placed in the pericardium, brought out through the left side of the neck. The pericardium was closed. Another drain was placed in the anterior mediastinum with the tail going into the right pleural space. The chest was irrigated with antibiotic solution. Bilateral Marcaine pericostal blocks were performed. The sternum was closed with interrupted wires. The fascia and skin were closed with running absorbable sutures. The wounds were dressed sterile occlusive dressings. The patient was then transported to the CICU in stable condition.

Ronald R Quinton, MD

Job#: 26097457 D: Wed Nov 10 14:43:30 2010 EST T: Wed Nov 10 15:33:52 2010 EST
DOB: 4 - Healthcare info... MLS#: 97674
cc: William P Brennan, MD; Kirk W Harris, MD

Adm. Date: **11/10/2010** Ronald R Quinton, MD
Room#: CC05 1 Age: 74 MR: 0001079775
PATIENT: 4 - Healthcare information readil... PT: 1030600302

OPERATIVE REPORT

COPY for Kirk W Harris, MD

000058

11/09/10 4 - Health... /Teresa

Follow up call. I (Teresa) called 4 - Healt... to see how her appt with Dr. Brennan went. She became very angry and states that she & her sons are upset. She feels like these signs/symptoms have been going on too long. After talking with Dr Brennan, 4 - Healt... states that he even feels the same way. I suggested that she talks to Dr. Harris about her feelings and she refuses and states "that he is lucky that her son Greg has not showed up in person to talk about this with him. Both of my sons are very angry with him as well." She will be having open heart surgery tomorrow on 11/10/10 @ 5:30am to replace a valve. Depending on the outcome Dr. Harris will be receiving a letter from her lawyer and also "how dare Lynn call her about a bill that her insurance didn't pay. I (4 - Hea...) told Lynn wait until you see my hospital bill you will be getting. This is all Dr. Harris' fault." 4 - Healt... asked me to relay this information to Dr. Harris. 4 - Heal... then asked why we told her that her EKG was normal when cardiologist's test was abnormal. I (Teresa) explained the difference between an EKG and a nuclear cardiolyte study. How our test is a resting test and the cardiolyte is a stress test with medication injection, which stresses the heart. After the explanation of the difference between the tests, she seemed to calm down. I (Teresa) again asked if she would like to talk to Dr. Harris, so she could go over these feelings. Again, she declined. She gave me her son Greg's phone number, incase I wanted to check on her @ Mother Joseph's.

Joyce Tuitele 11/9/10

Please give 4 - Healt... a call and see how she is doing.

I'm glad they found her heart valve problem.

Has she already gone for the surgery to open up her constricted valve?

WKHpc

11/9/10 Very upset c Dr Harris. Has been c/o sx these 8/s for a long time. felt like he did Nothing open Heart surg on 11/10/10 @ 5:30 Am Dr Quintin Stokes.

PHONE MEMO

TO Dr. Harris DATE TIME Message AM PM

FROM Cardiology Assoc. OUT PHONE 360-) 413-8525

OF Pat - Dr. Brennan CELL ( ) Fax ( ) TALKED W/ PAT AT LENGTH ABOUT JUICE 11-4-10

MESSAGE Dr. Brennan would like to speak w/ you re: 4 - Healthcare information... Tuitele

TALKED AT LENGTH W/ DR. BRENNAN

E-MAIL ADDRESS + 4 - Healt... 2pm - 3pm. SIGNED

PHONED CALL BACK RETURNED CALL WANTS TO SEE YOU WILL CALL AGAIN WAS IN URGENT

000060

ARICEPT (donepezil HCl) 5-MG AND 10-MG TABLETS

He's going to get a lawyers letter from Her, Dr. Berman & tell all his sis came from this problem

ARICEPT (donepezil HCl) 5-MG AND 10-MG TABLETS

Greg (Son)
707-628-3493

CHF
SOB
SYNCOPE
CP

WOULD NOT HAVE DONE ANYTHING DIFFERENT UNTIL SHE BECAME SYMPTOMATIC

Providence St. Peter Hospital
Olympia, Washington

Clinical Data: POST CABG Diagnostic Imaging

CHEST 1V PORTABLE

DATE OF EXAM: 11/11/2010

INDICATION: POST CABG

VIEWS: One-view portable chest

COMPARISON: 11/04/2010

FINDINGS: There are mediastinal drains present. Right internal jugular Swan-Ganz catheter lies at the pulmonary artery outflow tract. Coronary artery bypass graft changes and median sternotomy present. Possible aortic valvular prosthetic ring present. Heart is within normal limits in size for postoperative film. Slight prominence of the upper mediastinum consistent with a small amount of postoperative blood. Old granulomatous changes within the left apex and left upper lobe lung. No evidence of pleural effusion. Degenerative changes thoracic spine.

IMPRESSION:

1. Within normal limits for postoperative film

Dictated By: Steven J. Lengle, M.D. 11/11/2010 8:50:38 AM

signed: STEVEN J. LENGLE, M.D.
SOUTH SOUND RADIOLOGISTS

SL/sl

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PT.NAME: 4 - Healthcare information readily ide...
EXAM DATE: 11-Nov-10
REF PHY: RONALD R QUINTON, MD
ROOM: CC05-1
PT TYPE: IPO

XRAY#: 431663
PT#: 1030600302
EXAM#: 94A-111110
DOB: 4 - Healthcare information r...
PT AGE: 74

MR#: 1079775
ACCESSION#: 82032237
PCP: W KIRK HARRIS, MD
CC:
CC:

000062

William P. Brennan, M.D.
Roger S. Chan, M.D.
William A. Gavin, M.D.
Richard P. Kennedy, M.D.
Qiang Li, M.D.

Cardiology Associates, PLLC

David H. Schoening, M.D.
Robert S. Wark, M.D.
Craig J. Wehrli, M.D.
Christopher L. Wolfe, M.D.
Willa Nizolek, B.S.N., M.B.A.

November 2, 2010

W Kirk Harris, MD
6981 Littlerock Road, #101
Tumwater, WA 98512

RE: 4 - Healthcare information readily ...
143-249-508
4 - Healthcare i...

Dear Kirk,

Today I performed angiography o 4 - Healthcare information re... As you recall, 4 - Heal... came to the office for Lexiscan Myoview study and had marked chest pain with Lexiscan infusion. For that reason I saw her on consultation and because of her impressive history of angina, proceed on to angiography today. She also had a noted murmur so we performed right and left heart catheterization.

The study demonstrated significant aortic stenosis with a mean gradient of 41 mmHg and a valve area of 0.6 cm2. Her coronary arteries were normal and her left ventricular function was normal.

Thus, I believe 4 - Healt...'s symptoms are on the basis of her aortic valve disease. She will be seen today by Olympia Cardiac Surgery with the arrangements to be made for aortic valve replacement.

Again, it was a pleasure to assist in 4 - Healt...'s care. A copy of her consult note and catheterization report should be coming to you directly from St. Peter Hospital.

Sincerely,

William P. Brennan

William P Brennan MD

[Created: WILLIAM P BRENNAN MD on 11/02/2010 at]
[Transcribed: mj on 11/05/2010 at 08:24 AM]
[Approved: JESSICA JOHNSON_MA for BRENNAN, WILLIAM P MD on 11/05/2010 at 10:01:57 AM]
[Finalized: 11/05/2010 at 10:01:57 AM]
cc.

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PROVIDENCE ST. PETER HOSPITAL
Olympia, Washington

(This information may be protected by Federal and/or State Law prohibiting further disclosure.)

Admit Date: 11/02/2010

DATE OF CONSULTATION: 11/02/2010

TO:

CONSULTATION DATE: 11/02/2010

SUBJECTIVE: The patient is a 74-year-old Scottish female who has had progressive chest pressure, some pain, some dyspnea on exertion and increasing tiredness. She is found to have critical aortic stenosis. I have been asked to see the patient for consideration for aortic valve replacement. The patient has been told in the past she had a murmur of aortic stenosis but had been asymptomatic. She has had some lightheaded spells but no blackout spells. She denies any history of ischemic heart disease or arrhythmias or admissions for congestive heart failure. She is now able to walk approximately 100 feet without getting short of breath, consistent with XXXXXXXXXX Heart Association functional class II heart failure which would be chronic systolic.

PAST MEDICAL HISTORY: Hypertension, hypercholesterolemia, non-insulin dependent diabetes mellitus, recently diagnosed. Chronic kidney disease stage 3 which developed after her hip surgery in 2004.

PAST SURGICAL HISTORY: She has had bilateral hip replacements.

ALLERGIES: Codeine makes her feel ill.

MEDICATIONS: Aspirin 325 mg a day, fluoxetine 40 mg q.a.m., lorazepam 50 mg q.a.m., hydrochlorothiazide 25 mg a day, Lanoxin 0.25 mg a day, metformin 500 mg b.i.d., simvastatin 40 mg a day.

HABITS: Tobacco: None. Alcohol: None.

SOCIAL HISTORY: The patient is widowed. She does have 2 sons in the area for support.

REVIEW OF SYSTEMS: Those symptoms noted in the present illness otherwise the patient has a negative review of systems. I have nothing to add to Dr. Brennan's history and physical.

PHYSICAL EXAMINATION: GENERAL: The patient is a healthy-appearing, well-developed, well-nourished 74-year-old female in no acute distress. **VITAL SIGNS:** Normal. **HEENT:** No bruits. No JVD. No scleral icterus. **CHEST:** Symmetrical. **BREASTS:** Not examined. **LUNGS:** Clear to auscultation. **HEART:** Regular rate and rhythm with a 3/4 systolic murmur at the left upper sternal border. **ABDOMEN:** Soft, no tendemess, no pulsatile masses. **EXTREMITIES:** Show full range of

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motion without clubbing, cyanosis, edema. **NEUROLOGIC:** Peripheral reflexes are intact. **SKIN:** No rashes or lesions.

DIAGNOSTIC STUDIES: EKG demonstrates normal sinus rhythm, left ventricular hypertrophy.

Her hematocrit was normal at 41, platelet counts normal. Her creatinine is elevated at 1.51 with a peak of 1.57 back in May. Her GFR was 34. Electrolytes are normal.

Chest x-ray really has no significant abnormalities.

Cardiac cath: I do not have a dictated report but from my review of the films and Dr. Brennan's note she was found to have normal coronary arteries. Normal left ventricular function. She had an aortic valve gradient of 43 mean. The aortic valve area is not calculated on the note.

ASSESSMENT: A 74-year-old with severe to critical aortic stenosis becoming progressively symptomatic. At this point, she would benefit from surgical replacement of aortic valve. I have discussed the diagnosis and planned procedure with the patient including the expected benefits, usual risks and alternatives. We discussed use of a tissue valve versus a mechanical valve with their advantages and disadvantages and my recommendation for a tissue valve. The patient states she understands and wishes to proceed. We will need to wait 4 days to rule out contrast-induced nephropathy, given her baseline chronic kidney disease. I have, therefore, scheduled her for November 10, 2010.

PLAN: The patient will be scheduled for surgery on November 10, 2010. Routine preoperative preparation done prior to that time.

Thanks for allowing me to participate in her care.

Ronald R Quinton, MD

Job#: 25872904 D: Tue Nov 02 14:57:23 2010 EST T: Tue Nov 02 15:30:43 2010 EST
DOB: 4 - Healthcare i... MLS#: 97906
cc: Kirk W Harris, MD; William P Brennan MD

Adm. Date: **11/02/2010** Ronald R Quinton, MD
Room#: Age: 74 MR: 0001079775
PATIENT: 4 - Healthcare information readil... PT: 1030600038

CONSULTATION

COPY for Kirk W Harris, MD

TRA | Medical Imaging
ON LILLY
formerly Northwest Radiology Group

500 Lilly Road I Olympia, WA 98506 I tel [360] 413-8383 I fax [360] 413-8323

Imaging Report

DATE OF SERVICE: 10-29-10

PATIENT NAME:
4 - Healthcare information re...

REFERRING PHYSICIAN:
WILLIAM P BRENNAN, MD

ACCOUNT NUMBER:
739329

500 LILLY RD NE STE 130

DATE OF BIRTH/SEX:
4 - Healthc... /F

OLYMPIA, WA 98506-

TWO VIEW CHEST

HISTORY:
Precordial pain.

COMPARISON:
None.

FINDINGS:
Two views. Cardiac silhouette is normal in size. Mediastinal contours are normal. There is mild linear increased density demonstrated within the left apical lung tissue. Focal areas of calcification, oval, and round are demonstrated within the left upper lobe. This could be related to pulmonary nodules. Small pleural plaques are not completely excluded. The right hemithorax is clear. There is no focal bony abnormality. There is no pleural effusion, pneumothorax or dominant mass lesion. The trachea is midline.

IMPRESSION:
1. Linear areas of increased density demonstrated within the left upper lobe as can be seen with scarring from prior granulomatous change.

2. Multiple oval and round calcified masses within the left upper lobe and a single peripheral lesion in the left lower lobe, possibly related to old granulomatous disease or pleural plaquing. CT scan of the chest can be utilized for further evaluation.

Thank you for this referral. For consultation with the radiologist, please call 360-413-8383.

JOANNA PRESCOTT, MD

WILLIAM KIRK HARRIS, MD

10-29-10

Approved By: JOANNA PRESCOTT 10-29-2010 05:12:47 PM

William P. Brennan, M.D.
Roger S. Chan, M.D.
William A. Gavin, M.D.
Richard P. Kennedy, M.D.
Qiang Li, M.D.

Cardiology Associates, PLLC

David H. Schoening, M.D.
Robert S. Wark, M.D.
Craig J. Wehrli, M.D.
Christopher L. Wolfe, M.D.
Willa Nizolek, B.S.N., M.B.A.

CONSULTATION
October 29, 2010

W Kirk Harris, MD
6981 Littlerock Road, #101
Tumwater, WA 98512

RE: 4 - Healthcare information readil...
143-249-508
4 - Healthcare i...

REFERRING PHYSICIAN: W Kirk Harris MD

REASON FOR VISIT:
Chest Pressure/Tightness
DM Non-Insulin Controlled
Hypertension Controlled
Hypercholesterolemia

HPI:
4 - Healthcare inform... is a 74 -year-old female i am asked to see because of chest pain, dyspnea and abnormal Lexiscan Myoview study.

The patient has had several months of chest pain. She describes her status post as a substernal tightness without radiation. It is progressed to occurring a couple of times a day. She describes it as moderate and at other times severe. It can last up to ten minutes. This is specifically brought on by exertion such as walking and is relieved with rest. It is associated with dyspnea. She has had the pain at rest without any activity.

In addition, the patient complains of increasing problems with dyspnea. She states she can walk maybe 100 feet and then has to stop and breathe hard before she can go any further. She has had no orthopnea or paroxysmal nocturnal dyspnea or peripheral edema. She has had palpitations but no sustained racing of her heart. She has had no lightheadedness, syncope or near-syncope. She does have a history of a heart murmur.

RISK FACTORS:
Positive for hypertension; diabetes, hypercholesterolemia and family history of coronary artery disease. This is negative for smoking.

PAST MEDICAL HISTORY:
SURGERIES –
Right ear surgery, remote.
Bilateral hip replacement in 2001 and 2004
ILLNESSES –
Tuberculosis, remote
Type-2 diabetes.
Hypertension.
Hypercholesterolemia
HABITS – The patient denies alcohol abuse.

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CURRENT MEDICATIONS:

FLUOXETINE CAP 40mg 1 CAP PO QDAY in the morning
FLURAZEPAM CAP 15mg 1 CAP PO QDAY
HYDROCHLOROTHIAZIDE TAB 25mg 1 TAB PO QDAY
INDOMETHACIN CAP 25mg 1 CAP PO TID WITH FOOD
LANOXIN TAB 0.250mg 1 TAB PO QDAY
METFORMIN TAB 500mg 1 TAB PO BID with morning and evening meals
SIMVASTATIN TAB 40mg 1 TAB PO QDAY in the evening

Allergies and Intolerances—No known drug allergies.

SOCIAL HISTORY:
The patient is a widow with two sons. She lives at home. She is not currently working.

REVIEW OF SYSTEMS:
General- The patient reports fatigue, recent weight loss and sweats, but denies fevers or chills. Skin- No rashes. HEENT- The patient reports dizziness and hearing problems, but denies headaches or vision problems. Lungs- The patient reports orthopnea and DOE, but denies PND or wheezing. Heart- The patient reports chest pressure, heart murmurs and palpitations, but denies chest pain or heart murmur. GI- The patient reports loss of appetite, but denies bleeding from bowels, constipation, diarrhea, heart burn or indigestion. GU- No burning with urination, frequent urination or incontinence. Extremities- The patient reports arthritis, but denies ankle swelling or difficulty walking. Neuro- The patient reports difficulty with coordination and forgetfulness, but denies numbness or seizures. Psych- The patient reports anxiety and depression.

HABITS:
Tobacco- Never

PHYSICAL EXAMINATION:
VITALS- BP 190/90 Pulse 108 (Initial LA Sitting Large Cuff), Weight 190 lbs, Height 63 inches
CONSTITUTIONAL- The patient is well-appearing and is in no acute distress.
NECK- No significant JVD. No adenopathy.
CHEST- Grossly normal.
LUNGS- Clear to auscultation.
HEART
RHYTHM- Rhythm is regular.
PALPATION- PMI is within the MCL.
VALVES- S1 and S2 are normal.
GALLOPS- There is no S3 or S4.
AORTIC VALVE- Normal.
MITRAL VALVE- Normal.
ABDOMEN- Benign without hepatomegaly or splenomegaly.
EXTREMITIES- No clubbing, cyanosis or edema.
NEURO- Grossly intact.
PSYCH- Nonfocal and oriented to time and place without mood disturbance.

LIPID PROFILES:

	02/19/2009	05/27/2010	09/21/2010
CHOLESTEROL	-	-	-

HDL	-	-	-
LDL	-	-	-
SGOT	22	25	25
SGPT	19	24	25
TRIGLYCERIDES	-	-	-

Resting electrocardiogram demonstrates normal sinus rhythm with ST segment depression in V3 – V6; cannot exclude anterior ischemia.

With the Lexiscan Myoview the patient developed reproduction of her chest pain and had further decrease from 1 to 2-3 mm of ST segment depression in the same leads. Her stress images did show an apical defect as well as a septal defect. Resting images are pending. However, because of her history, we went ahead and saw her in consultation today.

IMPRESSION:
1. Rule out coronary artery disease characterized by;
   a. Class-3 limiting effort angina and dyspnea;
   b. Positive Myoview with ST segment depression and chest pain with Lexiscan effusion images pending;
   c. Resting anterolateral ST segment depression.
2. Diabetes mellitus, type-2.
3. Hypertension.
4. Hypercholesterolemia.

PLAN:
1. Discontinue INDOMETHACIN CAP 25mg 1 CAP PO TID WITH FOOD.
2. Start ASA 325mg 1 TAB PO QDAY.
3. Start NITROGLYCERIN SUBLINGUAL TAB 0.4mg Place 1 TAB SL at the 1st sign of an attack - may repeat every 5 min until relief up to a maximum of 3 doses.
4. Right & Left Heart Catheterization +/- Intervention at SPH-- The patient has been fully advised concerning the alternatives, benefits and risks of cardiac cath including, but not limited to, the risk of MI, vascular injury, CVA and death. The patient has also been consented for the potential of coronary intervention (including PTCA, coronary atherectomy or coronary stenting) as well as the potential risk of emergent CABG and of restenosis requiring secondary procedures. The patient gives informed consent and wishes to proceed. The procedure will be scheduled for (428.1 and 786.51) next week.
5. Basic Metabolic Panel (414.01) today.
6. Chest, 2 view (786.51) today.

We will set the patient up for right and left heart catheterization. We will evaluate her murmur and make sure she does not have aortic stenosis. We will keep dye load to a minimum because of her elevated creatinine in the past. We will check her creatinine today.

William P. Brennan

William P Brennan MD

[Created: WILLIAM P BRENNAN MD on 10/29/2010 at 01:03 PM]
[Transcribed: mj on 10/29/2010 at 03:38 PM]

Cardiology Associates, PLLC

ICAEL

MAIN OFFICE 500 N Lilly Rd. Olympia, WA 98506 Phone: (360) 413-8525 Fax: (360) 413-8837

ETT- CHEMICAL NUCLEAR
NUCLEAR MEDICINE, CA
10/29/2010

4 - Healthcare information readily...
143-249-508
4 - Healthcare i...

REFERRING PHYSICIAN: W Kirk Harris MD

CHEMICAL NUCLEAR DATA:

CPT * :	Myocardial Perfusion (78452) Stress Test (93015)	Stress Indications * :	Dyspnea (786.05)
Gender:	Female	Protocol:	Lexiscan 2 Day
Age:	74 yrs	Duration:	4 mins 0 secs
Height:	63 inches	Peak HR:	120 bpm
Weight:	170 lbs	Peak BP:	105 / 82
		Pharm Agent1:	Lexiscan IV
Resting HR:	94	Pharm Agent Dose1:	0.4 mg
Resting BP:	163 / 81	Pharm Agent2:	
LVEF:	%	Pharm Agent Dose2:	
Isotope Rest Name:	Myoview IV	Isotope Stress Name:	Myoview IV
Isotope Rest Dose:		Isotope Stress Dose:	31.4 mCi

ECG REST: Anterior ST depression. Lateral ST depression. Normal sinus rhythm.

ECG STRESS: 2.0 mm down-sloping ST depression in the lateral leads during stress test. More pronounced then at rest where it is approx. 1mmHg depressed.

NUCLEAR FINDINGS: The stress images are within normal limits. The attenuation corrected images are also within normal limits. There is no rest images available.

CONCLUSIONS: 1. Normal stress images. Rest images are not available. Therefore, most likely this is a normal myocardial perfusion stress test, except possible transient cavitary dilatation.

INTERPRETED BY: Qiang Li, MD

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NOV -8 2010

[Created: NUCLEAR MEDICINE on 10/29/2010 at 12:10 PM]
[Transcribed: jp on 11/03/2010 at 05:12 PM]
[Approved: SANDY ZABROSKI_RN for NUCLEAR MEDICINE, CA on 11/04/2010 at 08:40:38 AM]
[Finalized: 11/04/2010 at 08:40:38 AM]

cc.
W Kirk Harris MD|6981 Littlerock Road, #101|Tumwater, WA 98512

000070

Cardiology Associates, PLLC

William P. Brennan M.D — ***Robert S. Wark M.D.***
William A. Gavin M.D. — ***Craig J. Wehrli M.D.***
Richard P. Kennedy M.D. — ***Christopher L. Wolfe M.D.***
David H. Schoening M.D.

500 Lilly Rd NE
STE 130
Olympia, WA 98506
(360)413-8525
Fax (360) 413-8800

Patient's Name: 4 - Healthcare information readily identifiable to a person -...
Patient's Phone:
Referring Doctor: ***W. KIRK HARRIS M.D.***
Phone (360)943-3633 fax (360)528-4643
Patient's Insurance: MA
Reason for visit: CP, Pox 94%
Cardiologist preferred: _____

Test or Visit Ordered:

10/29/10
@ 12pm

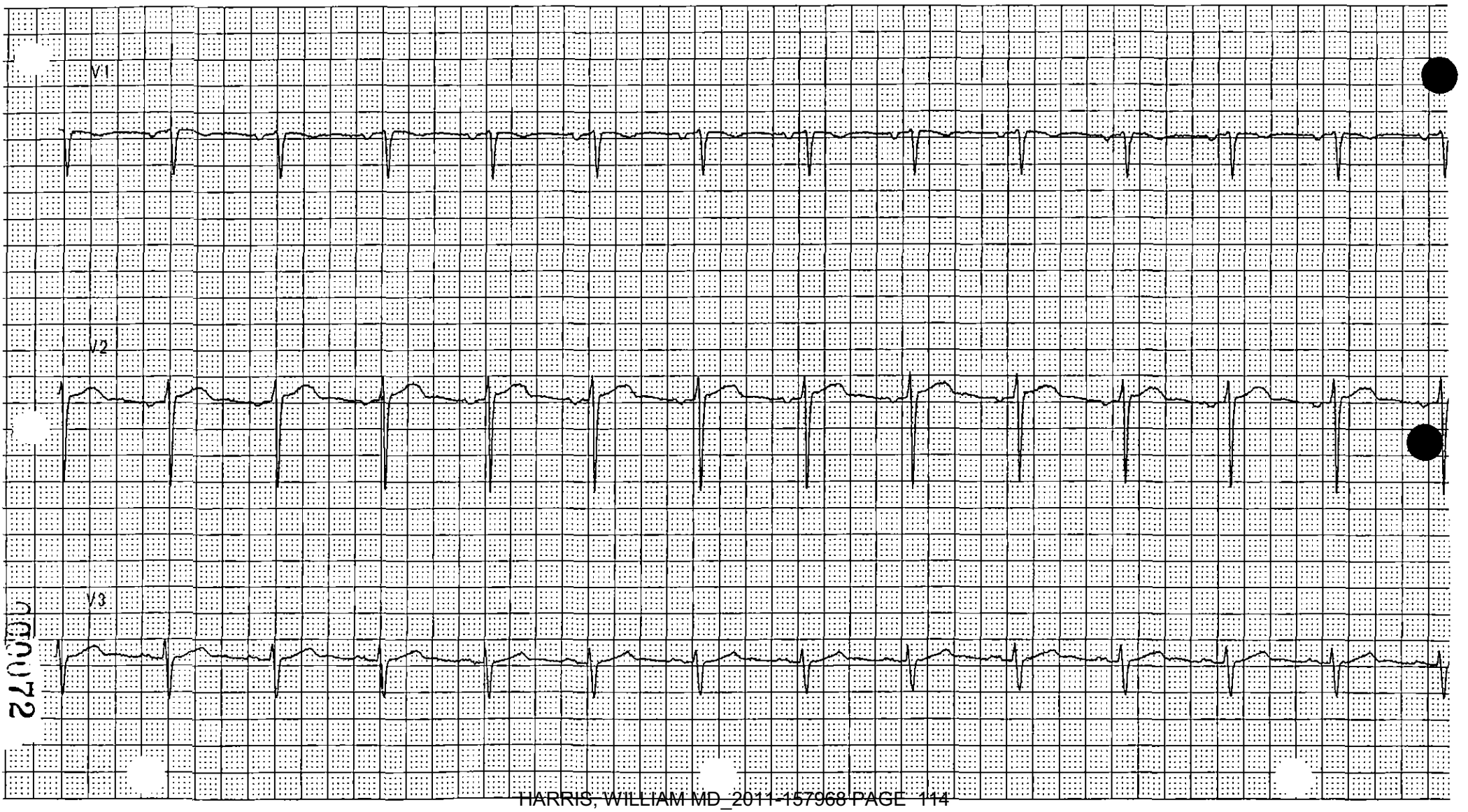
( ) Echocardiogram (93307, 93320, 93325)
( ) Electrocardiogram (93000)
( ) Holter Monitor (93230)
( ) Event Monitor (93268)
( ) Cardiac Consult (99241 99245)
( ) Tredmill (93015)
( ) Stress Echocardiogram (93550, 93015)
(X) Nuclear Cardiolyte Study (78465 78478 78480 99070 A9500)
( ) Other

FAXED
96-
10-4-10
cw

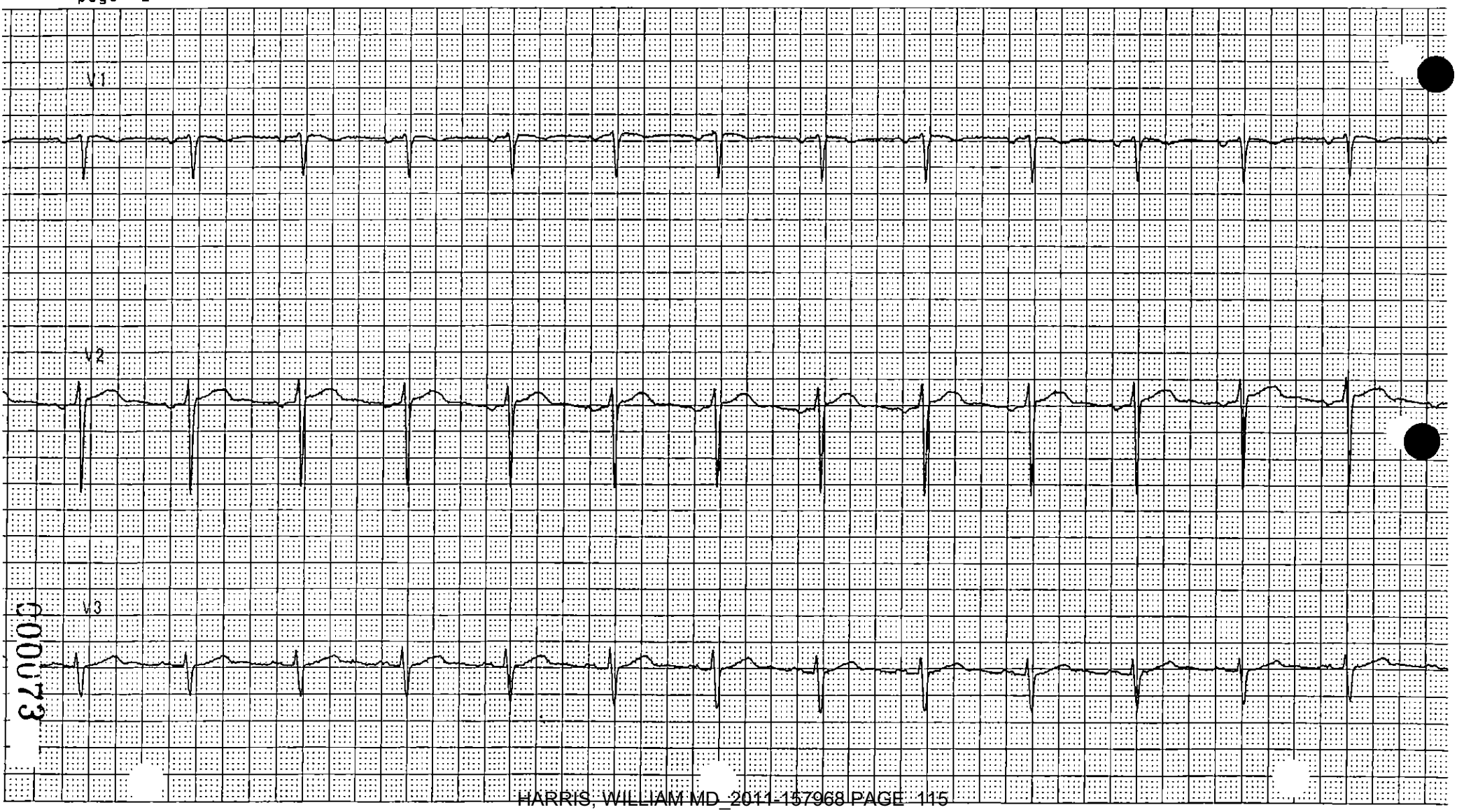
Can the patient exercise? NO
For nuclear study patient's weight 185 *height* 5'3

Name: 4 - Healthcare information r...
ID :
13:21 10/04/10
Speed: 25 mm/s ECG filter: Off
Gain : Limb 10 Chest 10 mm/mv

page 1

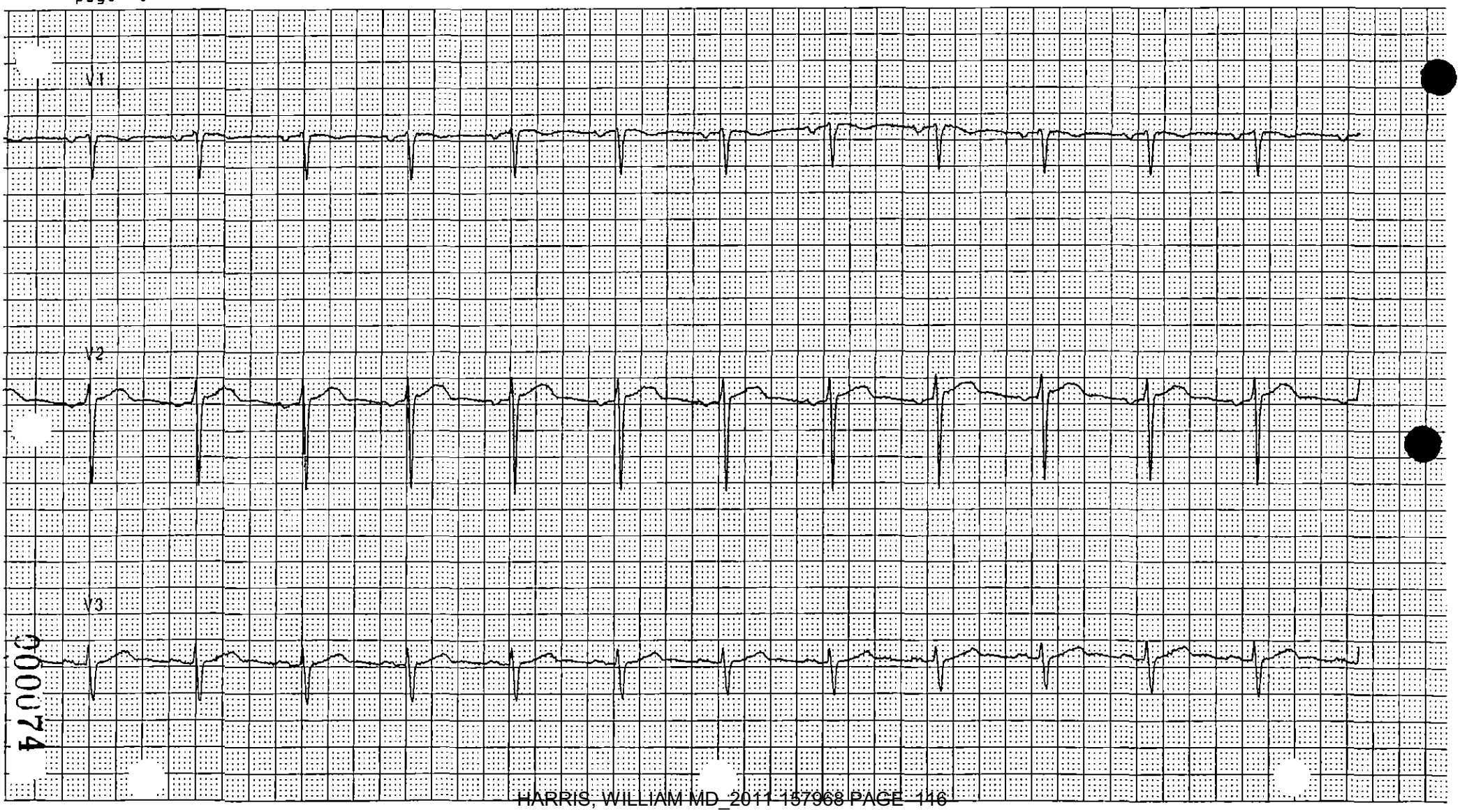


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Gain : Limb 10 Chest 10 mm/mv



Name: 4 - Healthcare information r...
ID :
13:21 10/04/10
Speed: 25 mm/s ECG filter: Off
Gain : Limb 10 Chest 10 mm/mv

page 3



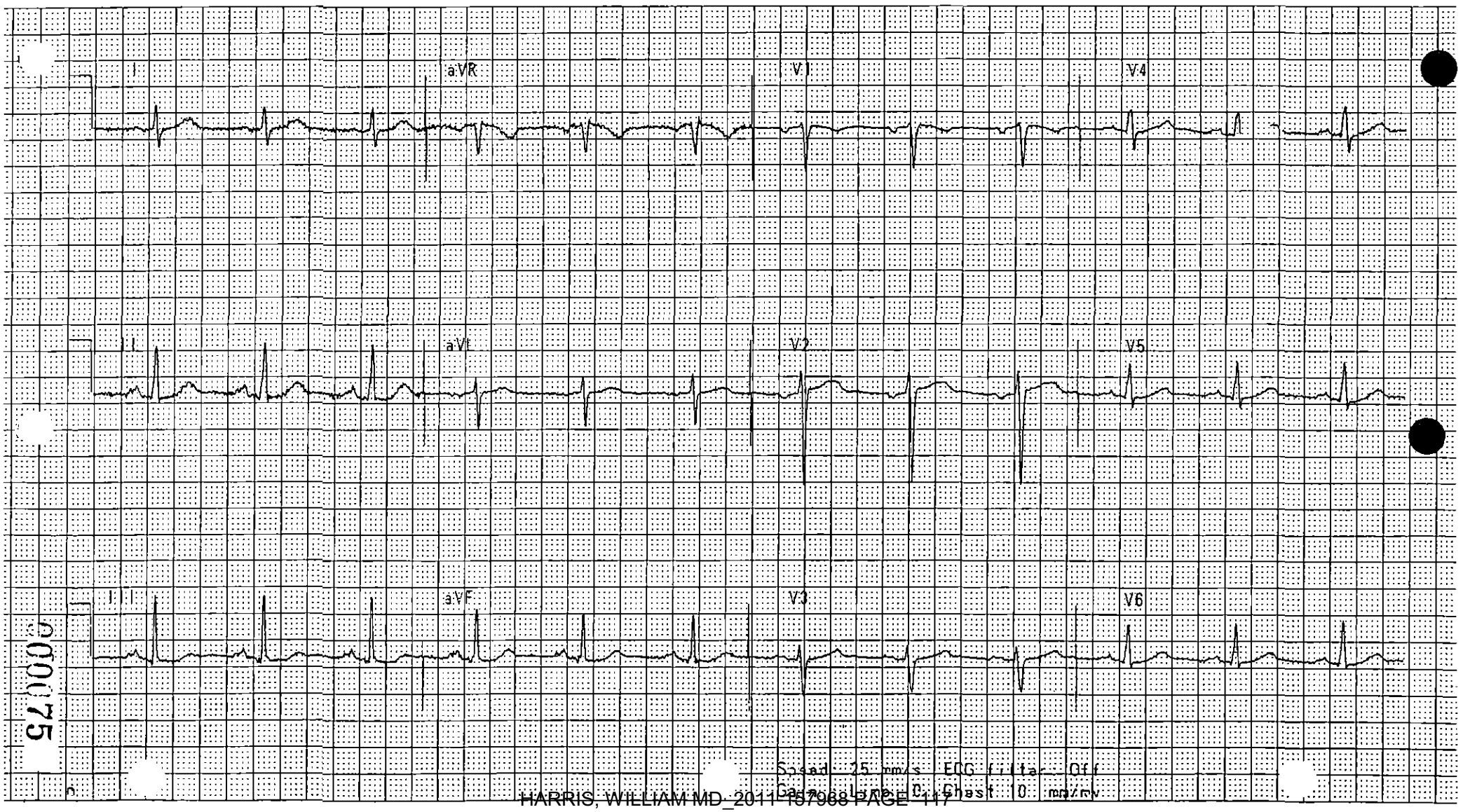
600074

Name: 4 - Healthcare information readily identifia...
ID :
Age : 74 Sex : Female
Hgt : 53 Wgt : 195
B/P : 139/78 Race: Caucasian
Optn:
Med1: None
Med2: None
Tech: TN Dr. : HARRIS
Site: 0 Unit: 0
Date: 10/04/10 Time: 13:20

Vent	Durations			Axes		
Rate	PR	QRS	QT/QTc	P	QRS	T
72	172	88	384/409	79	79	45

SINUS RHYTHM
NORMAL ECG

WKH



W. Kirk Harris, MD
Littlerock Family Medicine

6981 Littlerock Rd SW #101
Tumwater, WA 98512

Tel: 360-943-3633
Fax: 360-528-4643

10/04/10

4 - Healthcare info...

74yo

09/10 CMP WNL. WBC 9, HCT 45, PLT 178. A1C 5.7. TSH WNL. Urine analysis showed a large amount of WBCs and she was treated with Bactrim DS bid x 10d for UTI. She is not complaining of any bladder symptoms today.

Patient is now off Atenolol and Lisinopril and her BP ranges 126-161/54-82 on HCTZ 25mg qd and Digoxin 0.25mg qd. Patient reports that her grandson was in a serious car accident and she has been under quite a bit of stress. For the past two days she has had well-localized, sternal chest tightness with associated SOB, fatigue and DOE.

She has been taking increased dose Prozac for one to two years and still feels very depressed and feels like she has no ambition whatsoever.

Patient reports that she has been feeling quite anxious and even panicky. She is dealing with quite a bit of family stress with her uncooperative, unsupportive sons and is seriously considering moving back to Scotland to simply get away from the whole situation. She also realizes, however, that it is an unreasonable idea and that she will probably be stuck here in a less desirable personal situation.

Otherwise she is doing well on Indocin for arthritis, Prilosec for heartburn, and Metformin with good blood sugar control.

Exam: 98.2° 20 95 139/78 195# Nonsmoker

WNWD elderly WF in NAD; pleasant, cooperative, talkative. EOMI, PERRL, TMs clear, pharynx benign. Teeth in adequate repair. No cervical nodes nor JVD. Heart RR w/o M. Lungs CTAT. Abd soft, flat, NT to palp w/o HSM nor masses; BS+. Extr FROM w/ strong, symmetrical pulses in the lower extremities; no CCE. Office EKG shows NSR 72.

Impression:

Chest Pain 786.50	Type 2 Diabetes 250.00
Left Shoulder DJD 715.11	Fatigue 780.79
PAF 427.81	C-spine DDD 722.4
CHOL 272.0	Hypertension 401.1
Gout 274.9	DJD Knee 715.16
Gastritis 535.50	Anxiety 300.00
Insomnia 780.52	Depression 311
UTI Resolved 595.0	

Plan: DC Prozac (ineffective). Wait five days and then start Lexapro 10mg qd for improved depression control. Other supportive measures described Ativan 0.5mg qhs-bid prn anxiety/panic at length with positive feedback.

Reassured the patient about the benign nature of her office EKG however, because of persistent symptoms, we will send her for a nuclear cardio light study. Room Air Pulse Ox is a reassuring 94%. Precautions given for calling/returning w/ positive feedback. Further evaluation / treatment as indicated. RTC prn.

Nature of the presenting problem: Moderate severity if not treated.

Counseling/Coordination of care: Discussion regarding impressions, prognosis, risk/benefits, treatment options, follow-up, patient education: 15-25minutes.

Medical Decision-Making: Multiple diagnoses w/ extensive amount of data to be reviewed, moderate complexity of decision making and moderate morbidity.

jrp

Harris, MD

W. Kirk Harris, MD
Littlerock Family Medicine

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Fax: 360-528-4643

9/21/2010

4 - Healthcare info...

74yo

Pt is complaining that she is lethargic, has not felt good for a year, is suffering with low BP, has a poor appetite and worsening depression. She says that her sons are no longer supportive of her and that she is more depressed than ever. If she sits up in bed and becomes dizzy, she lies back down. Some mornings it may take her an hour to slowly crawl out of bed. She is afraid that she is going to fall, because if she does, she is so weak she is unable to get herself up off the floor unless she can crawl to her stairs and get her rump up onto the first or second step in order to stand up again.
She's taking Metformin 500mg bid with blood sugar range 75-165. She feels lethargic and as if all of the vitality has been taken out of her.
Exam: 135/82 Room air pulse ox 96%
Cardiopulmonary exam benign. No LE edema.

Impression:		
	Hypertension 401.1	Type II diabetes 250.00
	Left shoulder OA 715.11	Fatigue 780.79
	PAF 427.31	C-spine DDD 722.4
	CHOL 272.0	C-spine strain 847.0
	Hypertension 401.1	Gout 274.9
	DJD knee 715.16	Gastritis 535.50
	Anxiety 300.00	Insomnia 780.52
	Depression 311	Adjustment reaction 309.9

Plan: Last month, we stopped Atenolol. This month we will stop Lisinopril. She will continue only on HCTZ for BP control and Digoxin 0.25mg qd for CHF management. RTC 1mo for interval assessment and BP diary review.
Because pt is so weak, we gave her a Lifeline application to complete.
Basic metabolic panel, CMP, CBC, TSH, UA and A1C. Will call patient w/ results when received. Precautions given for calling/returning w/ positive feedback. Further evaluation / treatment as indicated. RTC prn.

LKM

Harris MD

Urgent Care South

6981 Littlerock Rd SW, Tumwater WA 98512
Phone 360-943-3633 Fax 360-528-4643

'10 SEP 9 PM 5:11

NPI 158 866 2068

Date: _____

PATIENT INFORMATION

Name	Insurance	Soc Sec Num
4 - Healthcare information readily identifiable to a person - RCW 42.5...	MED TRICA.	4 - Healthcare information readily identifiable to a pers...

Usual Medical Provider	Reason for Visit	Age	Birthdate	Patient Telephone
4 - Healthcare information readily identifiable to a perso...	DIZZINESS	74	4 - Healthcare i...	6 - Identity - Whistleblower and whistlebl...

ALLERGIES	MEDICATIONS	LAST TETANUS
NO	LOTS.	6 YRS

CONSENT FOR TREATMENT AND RELEASE OF INFORMATION

I hereby consent to all surgical and medical treatment as ordered by the medical care provider or consultant who may assist him/her. I authorize Urgent Care south to release to my insurance company / Medicare the medical and surgical information required to settle my insurance/Medicare claim, and authorize assignment of insurance/Medicare benefits.

Parent or Guardian_____ Patient_____ Date_____

MEDICAL PROVIDER SECTION

T	R	P	BP	Wt	LMP	CC:
	20	57	109/52	190		x 3 days DIZZY, LIGHT-HEADED

79-127 pdc 97

9/9/2010

Joyce Toutelli
74yo

5/2010 CMP WNL except glucose 253, WBC 7, HCT 41, PLT 180, UA clear, TSH WNL, A1C 7.9.
Pt was started on Metformin 500mg bid and is happy to report that her blood sugars have ranged 79-127. She is taking Lanoxin 25mb qd, Atenolol 50mg qd, HCTZ 25mg qd and Zestril 20mg qd with BPs ranging 109-127/52-78. She has been quite dizzy saying that there are many days it takes her a few hours to get out of bed. Even then, she may still have some residual dizziness symptoms. Pt denies any colds, coughs, flus, fevers, chills, sweats, ear pain, sore throat, and dysuria. Pt c/o no itchy, rumny, eyes & nose nor sneezing. She is quite depressed regarding how her sons treat her and how much money she has given them through the years and yet they still seem to be completely ungrateful about everything she has given them to the point that she cannot rely on them to come mow her lawn for her. She is thinking about simply moving back home to England because, despite Prozac, she is crying daily.
Exam: 109/52 190# (she has lost 10# in 3mo)
HEENT and cardiopulmonary exams benign.

Impression:

Type II diabetes 250.00	Fatigue 780.79
C-spine DDD 722.4	PAF 427.31
CHOL 272.0	Hypertension (overtreated) 401.1
Gout 274.9	DJD Knee 715.16
Gastritis 535.50	Anxiety 300.00
Depression 311	Insomnia 780.52

Plan: Instructed pt to discontinue Atenolol because of hypotension. Continue other meds unchanged. RTC 1mo for interval assessment and BP diary review. Will check A1C at that time, as well. Precautions given for calling/returning w/ positive feedback. Further evaluation / treatment as indicated. RTC prn.

LKM

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07/01/10

4 - Healthcare inf...

74yo

Patient started taking Metformin 500mg bid and is happy to report that her blood sugar range has been 93-154, asymptomatic. Unfortunately she has not had this amazing improvement in the way she feels. She continues to have SOB unchanged from her previous, fatigue unchanged from her previous and still feels unsteady on her feet. She has not fallen but is bothered significantly but left shoulder discomfort.

Exam: 128/78

HEENT and cardiopulmonary exams benign. Shoulder has limited ROM because of pain although she can internally and externally rotate her arm and raise it slowly above the horizontal.

Impression:	Type 2 Diabetes 250.00	Left Shoulder OA 715.11
	Fatigue 780.79	PAF 427.31
	C-spine DDD 722.4	C-spine Strain 847.0
	Paroxysmal Atrial Fibrillation 427.31	
	CHOL 272.0	Hypertension 401.1
	Gout 274.9	DJD Knee 715.16
	Gastritis 535.50	Anxiety 300.00
	Insomnia 780.52	*Depression* 311

Plan: Continue current medicines unchanged. RTC one month for interval assessment and blood sugar diary review. If this is stable then we will see her less often because her blood sugars will then be seen on A1C to be stable and well controlled. Precautions given for calling/returning w/ positive feedback. Further evaluation / treatment as indicated. RTC prn.

jrp

Harris MD

000079

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06/03/10

4 - Healthcare inf...

74yo

05/10 CMP WNL except glucose 253. AIC 7.9. WBC 7, HCT 41, PLT 180. UA clear. TSH WNL.
The patient describes how she has been tired and been bothered by polyuria, polydipsia, blurry vision, and anhedonia.
Exam: 148/80 Random Accu-Chek 273 at 2pm
HEENT and cardiopulmonary exams benign.
Impression:

New Onset Type 2 Diabetes 250.02	
C-spine DDD 722.4	C-spine Strain 847.0
Paroxysmal Atrial Fibrillation 427.31	
CHOL 272.0	Hypertension 401.1
Gout 274.9	DJD Knee 715.16
Gastritis 535.50	Anxiety 300.00
Insomnia 780.52	Depression 311

Plan: Explained at length to the patient and her son, showing her labs from previous years, how her levels have been gradually been increasing to their current levels despite dietary efforts on her part. Start Metformin 500mg bid. Pt instructed to continue with prudent diet, weight loss, and regular exercise with positive feedback. RTC one month for interval assessment and blood sugar diary review.

jrp

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05/27/10

4 - Healthcare inf...

74yo

02/09 CMP WNL. AIC 6.1. TSH WNL.
05/09 C-spine MRI showed multi-level DDD changes with facet arthropathy and moderate-to-severe cenural canal stenosis at C5-6 and mild central canal stenosis at C3-4, C4-5, and C6-7.
Pt consulted with neurologist Dr. Lang on 06/16/09 regarding chronic neck pain and they recommended further studies. Carotid ultrasound showed no significant stenosis and C-spine films in neutral, flexion, and extension views showed retrolisthesis of C5 on C6 and moderate C5-6 DDD. The patient has continued to pursue her State Farm MVA claim but it generally accepted that the majority of her symptoms are preexisting.
She participated in multiple modality South Sound Physical Therapy from 10/09 through 02/10 and had some improvement in neck ROM and discomfort.
She complains of ongoing anxiety, aching left-chest pain, poor energy level and appetite, decreased weight and headaches with excessive sleeping during the day. As a result she has significant insomnia at night and would like a medicine to get her back on her normal sleep cycle.
She is still quite depressed on Prozac 40mg qd.
Exam: 156/87
HEENT and cardiopulmonary exams benign. The patient appears to be sharp and talkative, bright and alert but complains that she has had mental deterioration for the last several months because of her physical condition. She says she is more depressed now and has no ambition.

Impression:		
	Anxiety 300.00	C-spine DDD 722.4
	Depression 311	C-spine Stenosis 723.0
	Hyperlipidemia 272.2	Fatigue 780.79
	Hypertension 401.1	Insomnia 780.52
	DJD Knee 715.16	Gastritis 535.50
	Diet-Controlled Diabetes 250.00	

Plan: Start Wellbutrin SR 150mg bid for additional anti-depression effect.
She has a minimal degree of ROM/ROE with a small amount of discharge present in the EAC so we will give her Augmentin 500mg bid x10 days.
Restart Dalmane 15mg qhs for insomnia to get her back on track regarding sleep. Continue other meds unchanged.
Comprehensive metabolic panel, CBC, TSH, UA and A1C. Will call patient w/ results when received. Precautions given for calling/returning w/ positive feedback. Further evaluation / treatment as indicated. RTC prn.

jrp

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3/9/2010

4 - Healthcare inf...

74yo

Pt has been absent for 3mo. She is continuing to take Indocin 25mg tid and is continuing with multiple-modality PT and massage therapy 3x wk with no further improvement in her MVA neck pain. She still complains of posterior neck pain which radiates up into headache and less shoulder or scapular pain. She still has significantly limited neck ROM in that she can only turn her head 45° to the right and 25° to the left. She mostly uses her mirrors when changing lanes while driving and complains bitterly of significant difficulty in grabbing her seat belt, either with the right hand or the left hand in order to lock it into place. The Soma 350mg tid was ineffective at improving her neck discomfort radiating into the arms..

Exam: 144/82

She has significant limited C-spine ROM both turning her head, leaning her head and looking up. She has no trouble touching chin to chest.

Impression: MVA C-spine strain 847.0 History of moderately severe C-spine spinal stenosis

Plan: Start Robaxin 750mg bld-tid for MVA neck/shoulder spasm/tightness/pain. It does not appear that multiple-modality PT is helping her and I suspect that her moderately severe multilevel C-spine central canal stenosis is more responsible for her pain than her MVA at this point. Will search for other therapy that may gain her either more ROM or comfort. Precautions given for calling/returning w/ positive feedback. Further evaluation / treatment as indicated. RTC prn.

LKM

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MVA

12/10/2009

4 - Healthcare inf...

73yo

Pt is taking Indocin 25mg tid and is participating in multiple-modality physical and massage therapy 3xwk with improvement in her neck pain. She still complains of right neck discomfort radiating into the right shoulder and left-sided neck pain when she turns her head to the left. She is bothered by headaches as well as discomfort down the posterior neck into the upper back. She is tired and depressed all the time because of this relative disability her accident has caused.
5/09 C-spine MRI showed multilevel DDD. She was send to MRI and the neurologist for tingling sensation in the fingers of the right hand. This symptom has not changed in the intervening time. She is taking muscle relaxing medications daily, participating in a home exercise program and is only seeing minimal improvement in her condition generally. She has not reached maximum medical improvement.
Exam: C-spine has fair ROM, limited at the extremes. Palpation of the trapezius musculature does not reveal any trigger points.
Impression: MVA C-spine strain 847.0
Plan: Continue current medications and treatment.
Completed State Farm Insurance Physician's Report form indicating the above. It may take 3-6mos for this pt to reach maximum medical improvement given the slow response we have observed so far. Precautions given for calling/returning w/ positive feedback. Further evaluation / treatment as indicated. RTC prn.

LKM

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11/12/09

4 - Healthcare info...

73yo

State Farm MVA

Patient has been participating in multiple modality South Sound Physical Therapy for ongoing neck pain. Her treatment is primarily massage for neck pain due to cervical strain and prognosis is excellent. She has had decreased muscle guarding, pain, and tingling, but has continued symptoms of whiplash from the accident.

The patient still complains of feeling "out of sorts." She is light-headed at night. She still can only turn her head 90 degrees at times and this limits her driving because she cannot check lanes adequately. She is looking forward to an appointment with neurologist, Dr. Lang, with whom she has worked before regarding right hand tingling. She complains because her upper-shoulder pain radiating into neck pain and headache does not allow her to make her bed, vacuum, go grocery shopping by herself, or clean her house. She is very frustrated with this sudden change from her previous independence.

Exam: Afebrile

Patient does have decreased ROM of the neck. Palpation across the upper shoulders creates discomfort but does not reveal any trigger points. Patient appears to be tired and is not her usually animated self because of decrease energy level.

Impression: MVA C-spine Strain 847.0

Plan: Continue home exercises and physical therapy massage.

Wrote a note requesting that she have in-home-care services two to three hours a day, two to three days a week for one to two months while she recovers.

Start Soma 350mg qhs-tid for neck and shoulder spasm pain. RTC two to three weeks for interval assessment. Precautions given for calling/returning w/ positive feedback.

jrp

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10/08/09

4 - Healthcare inf...

73yo

02/09 CMP WNL. A1C 6.1. TSH WNL.
05/09 C-spine MRI showed multi-level DDD with severe central canal stenosis at C5-6 and mild spinal canal stenosis at C3-4, C4-5, and C6-7.
She saw neurologist, Dr. Lang, 06/15/09, regarding right hand tingling. Flexion/extension C-spine films showed retrolisthesis of C5 on C6 with ongoing, moderate DDD at that level which was treated conservatively. Incidental carotid ultrasounds showed no hemodynamically, significant, bilateral carotid plaque, although a bruit was heard. Patient is happy to report that, just with conservative care, her neck pain significantly improved until earlier this week. She hit a deer while driving on the Rode and it barely bumped her car. Then, twelve hours later, she was rear ended while taking money out of the ATM machine causing her car to slam into the pole. This did jar her and renewed her neck pain and restarted her hand tingling. She has also had some left-chest aching discomfort but denies associated SOB, dizziness, sweats, or radiating discomfort into her left arm.
She is quite upset about all of this and feels that Prozac 20 mg qd is inadequate to relieve her depression symptoms.
Blood pressure is well controlled on Atenolol, HCTZ, and Zestril. She has not had any racing heart or skipped beats on Lanoxin.
It has been a while since she had blood work update on Simvastatin.
She has not been taking Prilosec lately, and she has noticed that when she stops that medicine, she usually has a bit more stomach upset, heartburn, and sometimes this left-chest aching.
Exam: 16 57 149/83 205# Nonsmoker
WNWD elderly WF in NAD; pleasant, cooperative, talkative. EOMI, PERRL, TMs clear, pharynx benign. Teeth in adequate repair. No cervical nodes nor JVD. Heart RR w/o M. Lungs CTAT. Abd soft, flat, NT to palp w/o HSM nor masses; BS+. Extr FROM w/ strong, symmetrical pulses in the lower extremities; no CCE. Neck has generally decreased ROM. She has a III/VI systolic heart murmur.

Impression:	C-spine DDD 722.4	Paroxysmal Afib 427.31
	C-spine Stenosis 723.0	Bilateral Hip Replacements
	CHOL 272.0	Hypertension 401.1
	MVA C-spine Strain 847.0	Gout 274.9
	DJD Knee 715.16	Gastritis 535.50
	Diet Controlled Diabetes 250.00	
	Anxiety Disorder 300.00	Insomnia 780.52
	Depression 311	

Plan: Increase Prozac to 40mg qd.
Restart Prilosec 20mg qd-bid for GERD/chest-aching symptom. Continue other meds unchanged.
Will send the patient to multiple modality physical therapy for renewed neck discomfort and hand tingling.
Sent for interval FLP, A1C, and CMP. Precautions given for calling/returning w/ positive feedback. Further evaluation / treatment as indicated. RTC prn.
Nature of the presenting problem: Moderate severity if not treated.
Counseling/Coordination of care: Discussion regarding impressions, prognosis, risk/benefits, treatment options, follow-up, patient education: 15-25minutes.
Medical Decision-Making: Multiple diagnoses w/ extensive amount of data to be reviewed, moderate complexity of decision making and moderate morbidity.

jrp

Harris, MD

Providence St. Peter Hospital
Olympia, Washington

(nical Data: CAROTID STENOSIS Diagnostic Imaging

US CAROTID DUPLEX

DATE OF EXAM: 7/20/2009

INDICATION: CAROTID STENOSIS

TECHNIQUE: Real-time gray scale, color-flow, and pulsed Doppler analysis was performed of the extracranial carotid arterial systems bilaterally.

COMPARISON: None

FINDINGS: There are scattered irregular plaques with high degree of distal acoustical shadowing which involve the common and internal carotid arteries bilaterally left slightly greater than right but without elevated velocities. Velocities in the internal carotid artery plaque sites bilaterally correspond to less than 40% diameter stenosis category. Elevated velocities in the external carotid arteries of 132 cm per second on the right and 142 cm per second on the left represent moderate degree of stenosis.

Right:

	Systolic	Diastolic
ICA peak velocity (cm/sec)	75	20
CCA peak velocity (cm/sec)	88	19
ICA/CCA ratio	0.85	1.1

Antegrade flow is seen in the right vertebral artery.

Left:

	Systolic	Diastolic
ICA peak velocity (cm/sec)	68	17
CCA peak velocity (cm/sec)	72	14
ICA/CCA ratio	0.94	1.2

Antegrade a flow is seen in the left vertebral artery.

IMPRESSION:

1. Bilateral extracranial carotid plaques without hemodynamically significant degree of stenosis.
2. Antegrade flow in the vertebral arteries bilaterally.

Dictated By: Rodney Matsubara, M.D. 7/20/2009 4:40:53 PM

ADDENDUM: (21-Jul-09/13:20)
US CAROTID DUPLEX

(cont'd)

'T.NAME: 4 - Healthcare information readily identifi...
:XAM DATE: 20-Jul-09
:EF PHY: ROBERT LANG, MD
:OOM:
'T TYPE: DIO
XRAY#: 431663
PT#: 0920100387
EXAM#:70A-072009
DOB: 4 - Healthcare information r...
PT AGE: 73
MR#: 1079775
ACCESSION#: 18622460
PCP: W KIRK HARRIS, MD
CC:
CC:

Providence St. Peter Hospital
Olympia, Washington

nical Data: CERVICALSPINAL STENOSIS Diagnostic Imaging

SPINE/CERVICAL/5V

DATE OF EXAM: 6/26/2009

INDICATION: CERVICALSPINAL STENOSIS

VIEWS: Lateral view in neutral position, eight and with flexion and extension, AP

COMPARISON: None

FINDINGS: In neutral position there is 3-4 mm retrolisthesis of C5 on six. Alignment is, otherwise, normal. There is moderate disc space narrowing C5-C6. Mild to space narrowing present C4-C5. There is prominent osteophyte formation C5-6, moderate at C3-4 and mild at C4-5. There is also small anterior osteophyte inferior C6.

With extension, the retrolisthesis of C5 on six remains 3-4 mm. With flexion and the retrolisthesis is 2-3 mm.

IMPRESSION:

1. Retrolisthesis of C5 on C6. This reduces slightly with flexion.
2. Moderate degenerative disc disease C5-C6.
3. Spondylosis.

Dictated By: Thomas J. Luetkehans, M.D. 6/26/2009 2:57:09 PM

signed: THOMAS LUETKEHANS, M.D.
SOUTH SOUND RADIOLOGISTS

TL/tl

PT.NAME: 4 - Healthcare information readily ide...
EXAM DATE: 26-Jun-09
REF PHY: ROBERT LANG, MD
ROOM: UNK
PT TYPE: DIO

XRAY#: 431663
PT#: 0917700252
EXAM#: 259A-062609
DOB: 4 - Healthcare information r...
PT AGE: 73

MR#: 1079775
ACCESSION#: 18548936
PCP: W KIRK HARRIS, MD
CC:
CC:

000087

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Robert G. R. Lang, M.D.,
F.R.C.S. (C), F.A.C.S.

Rebecca Peterson,
M.S.N., A.R.N.P.

June 16, 2009

Kirk Harris, M.D.
6981 Littlerock Rd. SW
Tumwater, WA 98512

RE: 4 - Healthcare information readil...

Dear Dr. Harris:

Thank you for asking us to see this pleasant, 73 year old, right-handed female with complaints of right hand tingling.

HISTORY OF PRESENT ILLNESS: Ms. 4 - Healt... first noted tingling in her right hand, primarily the thumb, approximately two months in the past. She initially thought the symptoms were related to arthritis, however, the tingling would also include the entire hand at times. She noted that the tingling was not affecting her grip strength. She had concerns that the tingling could be related to vascular problems as two of her sisters have had blockages in the arteries of the neck and two other sisters have had aneurysms.

The tingling is primarily in the right thumb but at times extends up the arm to just above the elbow. The tingling does not occur in the left hand or arm. If she holds her hand upright flexed at the elbow the tingling occurs. She tends to sleep with her hand up under the pillow and does not notice the tingling occurring at that time. She has no pain in her neck or shoulder and has not had any headaches. She has had no problems with balance or coordination. She feels that she has been more cautious when walking since her hip surgery several years in the past. She has been taking indomethacin routinely for her arthritic pain.

PAST MEDICAL HISTORY: She had TB as a teenager and was treated while living in Scotland. She has hypertension, hypercholesterolemia, a cardiac murmur and depression. Surgical history includes left hip replacement in 2001, right hip replacement in 2003 followed by acute renal failure and right tympanoplasty in 1969.

Current medications include atenolol 1 qd, Lisinopril 1 qd, HCTZ 1 qd, indomethacin qd, Prozac qd and Lovastatin qd. She also takes another heart pill but does not recall the name. She has sensitivity to codeine which causes her to feel dopey.

SOCIAL HISTORY: She is a widow with two adult children. She moved to the Olympia area several years in the past from California. She was born and raised in Scotland and moved to the United States as a young adult. She retired in 1995 as a general manager for a hotel chain. She graduated from high school and has two years of college education. She has never smoked and does not drink alcohol. Her hobbies include knitting, reading and sewing.

FAMILY HISTORY: Her father died at age 78 from heart disease and CVA. Her mother died from a thrombus. Other family history includes CHF, CVA, heart disease, aneurysms and TB.

Suggests EMG's

REVIEW OF SYSTEMS: She rates her general health and well being as good and gets mild exercise. She has difficulty sleeping which is not related to her hand symptoms, nervousness, lightheadedness, hard of hearing, intermittent discharge from her right ear, her heart races or skips beats intermittently, heart murmur and hypertension. She was treated for TB as a teenager. She has stiff, painful, swollen joints, arthritis in her hands, gout in her right middle toe. She has diet controlled diabetes and has lost approximately 50 lbs since being diagnosed with diabetes. She has passed through menopause.

PHYSICAL EXAMINATION: This is a well developed right-handed female 5'3" tall weighing approximately 175 lbs. She declined to be weighed today. Heart rate is 66 and regular without holosystolic murmur. Blood pressure is 132/30. Carotid bruits are heard bilaterally, right stronger than left. Her lungs are clear and respiration non labored. The abdomen was soft and nontender, no palpable masses, no hepatosplenomegaly. She is alert and answers questions appropriately. Speech is clear.

Palpation of the cervical region reveals no localized tenderness. No muscle spasms are noted. She can flex her chin to her chest, extend to 30°, laterally flex 30° bilaterally and rotation to 70° right, 50° left. Shoulder abduction is to 180° bilaterally. Tricep, bicep and brachioradialis reflexes are depressed bilaterally. There is weakness of opposition bilaterally. Otherwise both arms are strong. Tinel's test at the wrist and elbow is negative bilaterally. Phalen's test is negative bilaterally. Vibration and temperature sensations are equal. Pinprick sensation is diminished on the tip of the right thumb. Hoffman's sign is negative bilaterally.

Gait is mildly widebased and slight stiff. Tandem gait is unsteady. Patellar and ankle reflexes are depressed bilaterally. Toes were downgoing. Tone was normal in the lower extremities. No clonus is noted.

RADIOLOGICAL FINDINGS: The report from the cervical MRI performed 5/14/09 was reviewed by myself and Dr. Lang. The films were not available. The radiologist reports 2 mm of anterolisthesis at C3 on C4 and C4 on C5. There are multilevel degenerative changes throughout the cervical region. At C3-4 there is moderate broad disk bulging and facet degenerative changes. There is marked severe right and moderate left neuroforaminal narrowing without significant central canal stenosis. At C4-5 there is a disk osteophyte complex with moderate facet degenerative changes. There was effacement of the ventral aspect of the thecal sac. Mild to moderate right and moderate to severe left neuroforaminal narrowing is reported. At C5-6 moderate to large circumferential disk osteophyte complex is reported with bilateral facet degenerative changes causing moderate to severe spinal stenosis with resultant deformity of the spinal cord. No cord abnormalities are reported. The neuroforamen are narrowed bilaterally. At C6-7 there is small broadbased disk bulging and facet degeneration with only mild neuroforaminal narrowing.

DIAGNOSIS: She has central canal stenosis at C5-6 and has signs of myelopathy. She has carotid bruits and stenosis should be assessed.

RECOMMENDATIONS: The history was reviewed with Dr. Lang and he also examined the patient. We have ordered cervical flexion/extension x-rays to assess for abnormal motion. We would recommend a carotid doppler or MRA of the cervical arteries if these have not already been performed. She will follow-up with Dr. Lang after the x-rays.

Sincerely,

Robert G.R. Lang, M.D.
RGRL:slm

Rebecca J. Peterson, ARNP
RJP:slm

Olympia Open MRI
669 Woodland Square Loop SE
Lacey, WA 98503
Phone: 360-413-9393
Fax: 360-413-9365
SOUTH SOUND RADIOLOGISTS, INC., P.S.

To: W KIRK HARRIS MD
6981 LITTLEROCK RD SW
TUMWATER, WA 98512-0000

Fax: 360-528-4643

Name: 4 - Healthcare information readily id...
Exam Date: **5/14/09**
DOB: 4 - Healthcare informat... Gender: **Female**
MRN #: **0168468**
Referring Phys.: **W KIRK HARRIS MD**

Exam: **MRI CERVICAL SPINE WITHOUT CONTRAST** **Laterality:** **Unpaired**

CERVICAL SPINE MRI

CLINICAL HISTORY: Right arm numbness.

PROCEDURE: Axial and sagittal T1 and T2 MRI sequences of the cervical spine were performed.

COMPARISON: None.

FINDINGS: The craniocervical junction is normal. No abnormal signal appreciated within the imaged portions of the spinal cord. Multi-level degenerative disc changes are present. There is 2 mm anterolisthesis C3 on C4 and C4 on C5. No suspicious marrow signal abnormalities.

Cervical disc levels:

C2-3: Mild bilateral facet degenerative changes. No spinal canal or neuroforaminal narrowing.

C3-4: There is a moderate sized broad based disc bulge and facet degenerative change. There is a mild degree of spinal canal stenosis. Neuroforaminal narrowing is moderate-to-severe on the right and moderate on the left.

C4-5: Small circumferential disc osteophyte complex and moderate facet degenerative changes. There is effacement of the ventral aspect of the thecal sac. Neuroforaminal narrowing is mild-to-moderate on the right and moderate-to-severe on the left.

C5-6: Moderate-to-large circumferential disc osteophyte complex and bilateral facet degenerative changes. There is moderate-to-severe spinal canal stenosis with resultant deformity of the spinal cord. No cord signal abnormality appreciated. Neuroforaminal narrowing is moderate bilaterally.

C6-7: Small broad base disc bulge and facet degeneration. Slight effacement of the

WKHpe

000091

ventral aspect of the thecal sac. Mild bilateral neuroforaminal narrowing.

C7-T1: Normal.

IMPRESSION:
1. Multi-level degenerative disc changes and facet joint arthropathy.
2. There is moderate-to-severe central canal stenosis at the C5-6 level. Spinal canal stenosis is mild at C3-4, C4-5, and C6-7.
3. Variable degrees of neuroforaminal narrowing as described.

EXAM PERFORMED AT OLYMPIA OPEN MRI.

Interpreting Radiologist

David B. Mitchell

DAVID MITCHELL MD
Electronically Signed: 5/15/09 2:11 pm

Technologist:
Typist: JMH
Typed: 5/15/09 10:27 am

W. Kirk Harris, MD
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05/13/09

4 - Healthcare inf...

73yo

02/09 CMP WNL except Glucose 120. A1C 6.1. TSH WNL.
Patient had a trip to Scotland and enjoyed herself but, after pulling luggage through the airport, ended up with some right neck pain. This has occurred off and on for the past two weeks and for the past few days she has had her entire right arm and hand tingling. This is especially bothersome when she drives, rests her arm on an armrest, lays her arm on an armrest, or sleeps. This is a pins-and-needles sensation more than it is true numbness. She is concerned because she has three sisters who ended up with neck surgeries for various similar symptoms.
Exam: 18 60 140/68 105#
Neck has full ROM. Shoulder, elbow, hand, and finger exam are unremarkable. She cannot tell any difference in sensation between the ulnar and radial sides of the hand nor top or bottom regarding sensation.
Impression: C-spine DDD With Radiculopathy 722.4
Plan: Will send the patient for C-spine MRI. Precautions given for calling/returning w/ positive feedback. Further evaluation / treatment as indicated. RTC prn.

Harris, MD

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2/09/09

4 - Healthcare inf...

73 yo

11/08 mammogram within normal limits.
Patient is looking forward to getting a full upper extraction with dental implants, and then she is going to go on a trip to Scotland for a vacation.
She is taking Metformin 500mg bid with resulting blood sugar range 87-102, asymptomatic.
Depression symptom are well controlled with Prozac 20mg qd. She is worried that her hair is falling out, but blood work last year showed no imbalance of thyroid, blood count, nor chemistry profile.
She is taking Atenolol 50mg qd, HCTZ 25mg qd, Zestril 20mg qd and Digoxin 0.25 mg qd with good control of BP. Pt denies any chest pain, shortness of breath, palpitations, racing heart, and skipped beats.
Complete Review of Systems otherwise minimized.
PMH: 4/08 CMP WNL except glucose 125. Glycohemoglobin 8.3, cholesterol 136, triglycerides 118, HDL 31, LDL 81, WBC 8, HCT 43, PLT 226, TSH within normal limits.
Exam: 18 70 144/79 (Patient refused weight). Nonsmoker.
WNWD obese WF in NAD; pleasant, cooperative, talkative. EOMI, PERRL, TMs clear, pharynx benign. She has many missing teeth. No cervical nodes nor JVD. Heart RR w/o M. Lungs CTAT. Abd soft, flat, NT to palp w/o HSM nor masses; BS+. Extr FROM w/ strong, symmetrical pulses in the lower extremities; no CCE.

Impression:	Type II Diabetes	Depression
	CHOL	Hypertension

Plan: Refilled Prozac 20mg qd and Lanoxin 0.25 mg qd. Continue other meds unchanged.
Comprehensive metabolic panel, CBC, TSH, FLP. Will call patient w/ results when received. Further evaluation / treatinent as indicated. RTC prn. Precautions given for calling/returning w/ positive feedback.

W Kirk Harris, MD

South Sound
Physical & Hand Therapy

www.southsoundtherapy.com

PHYSICAL THERAPY PROGRESS SUMMARY

PATIENT: 4 - Healthcare infor...

DATE: February 2, 2010

DIAGNOSIS: Neck pain.

REFERRAL SOURCE: Kirk Harris, M.D.

NUMBER OF SESSIONS COMPLETED: 18

CLAIM NUMBER: 4749130791

Dear Dr. Harris,

SUBJECTIVE: 4 - Healthcare infor... has been seen at South Sound Physical & Hand Therapy for evaluation and treatment of her neck pain. Since the last progress report sent she has been seen for four physical therapy and four massage therapy appointments. She reports a significant relief of neck pain although reports stiffness persists looking to the left more so than the right. She does note waking with tightness in her upper trapezius region. She reports compliance with her home exercise program and indicates she would like to continue with physical therapy to further address neck stiffness.

OBJECTIVE: Cervical spine exam finds left rotation limited to 30° as compared to 45° on the right. End range rotation elicits pulling stiffness pain in the midcervical spine contralaterally. Mild loss of cervical spine extension is noted and a moderate loss of right and left side bending is noted. Mobilizations to the upper cervical spine and the CT junction did significantly improve cervical spine left and right rotation. 4 - He... has been instructed in a home exercise program with an emphasis on stretching and muscle energy techniques to improve cervical spine mobility.

ASSESSMENT: 4 - Hea... is making good progress towards goals with reduction in neck pain and headaches. She now presents with stiffness as her primary limitation and is responding favorably to cervical spine joint mobilizations and stretching exercises. Hypomobility in the upper cervical spine is likely the main contributor to rotation range of motion restrictions and hypomobility in the lower cervical spine is contributing to a loss of extension motion. Her prognosis remains excellent and physical therapy is indicated to further address neck stiffness following MVA. 4 - Hea... has missed physical therapy visits over the past month due to adverse reactions to new medications and a flare-up of inner ear or vertigo symptoms.

TREATMENT PLAN: Physical therapy would like to continue to see patient at two times per week for physical therapy and one time per week for massage therapy. Treatment plan will consist of: 1) Manual therapy including joint mobilizations and soft tissue mobilization. 2) Modalities. 3) A home exercise program. 4) Neck range of motion and strengthening exercises. 5) Postural exercises. 6) Scapular stabilization exercises. 7) Strengthening of deep neck flexors.

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FAXED
FEB 10 2010
By KM

0095

W. Kirk Harris, MD
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[redacted]
10/23/08

72 years old

Blood sugars are 87-105 with diet control. No episodes of hypoglycemia.
Gout is well controlled with Indocin 25mg tid. Blood pressure is well controlled on atenolol 50mg, hydrochlorothiazide 25mg qd, and Zestril 20mg qd. Pt denies any chest pain, shortness of breath, palpitations, racing heart, and skipped beats.
The patient is interested in pursuing the finding of carotid bruit from the last visit. No signs of transient ischemic attack/ stroke. Complete Review of Systems otherwise minimized.
Exam: 18 72 147/80 205# (lost 50# in two years).
Cardiopulmonary exam benign. No LE edema. The patient has multiple missing and carious teeth and is deciding whether or not to get new teeth, buy a new house, or take a trip to England.

Impression:	CHOL 272.0	Gout 274.9
	Hypertension 401.1	Insomnia

Plan: Start Lunesta 2mg to 3mg qhs for insomnia. Continue other meds unchanged.
Sent for carotid ultrasound to evaluate carotid bruit. Consent form signed and flu shot administered with no reaction. RTC prn.

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08-27-08

4 - Healthcare informati...

72 years old.

Ms. 4 - Heal... came in today stating that she has had a flare up of her gout. She complains of pain in the right big toe and the 3rd digit of her right foot. The patients states that when she ambulates and bears weight that it does cause her some marked discomfort also. The foot she says feels hot to the touch.

Exam: 152/85 65 16.

Examination of her heart detects a slight systolic murmur. In her neck there was a small carotid bruits noted over the right carotid bruits which is approximately 1/6. Patients show me that she does have some erythema over the right foot and there is no evidence of any edema, it is somewhat warm to the touch, the radial pulse was still in tact. The first digit showed some marked erythema also and was painful when I palpated in that area. The normal phalanx of the 3rd digit of the right foot also shows some redness and their doesn't appear to be any swelling.

Impression: Gout Right Foot Carotid Bruits
Heart Murmur

Plan: I would like to initiate treatment with Colchicine 0.6 mg tabs 1 every 6 hours for pain relief ~~for~~ until tumor loose stool #12 no refills. She has Naprosyn at home that she will use 500 mg 1bid. RTC 1 month prior to the patient going on vacation to Scotland.

WKH

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07-24-08

4 - Healthcare informatio...

72 years old.

Patient came in today to recheck her blood sugar levels with a list of blood sugars levels that she has had taken at home for the month of July until now and the range in the low 90's lowest being 88 and high 103. Patient also has been seen on 6/18/08 for a UTI since that time she states that she has taken a treatment of Macrobid and says that her UTI has resolved and she is asymptomatic and afebrile.

Impression: Hyperglycemia UTI Resolved

Plan: Continue with current Regimen, medications, and RTC 1 month or on a prn basis.

Nature of the presenting problem: Moderate severity if not treated.

Counseling/Coordination of care: Discussion regarding impressions, prognosis, risk/benefits, treatment options, follow-up, patient education: 10-15 minutes.

Medical Decision-Making: Limited diagnoses w/ moderate amount of data to be reviewed, moderate complexity of decision making and moderate morbidity.

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06-18-08

4 - Healthcare informatio...

72 years old.

Pt c/o urinary burning, pain, hesitancy, frequency, urgency, nocturia, odor, and residual sensation for the past several days. Patient has felt fatigued, tired, unsteady, and has been slurring her words. Her sugars have ranged 90-107.

Exam: 18 76 126/72.

No CVAT. Urine dipstick positive for WBC's and RBC's. Abdomen is soft, flat, NT to palp, w/ no HSM nor masses; BS+.

Impression: UTI

Plan: Macrobid x10d. Other supportive measures including Pyridium 200 mg tid with positive feedback. RTC prn.

Nature of the presenting problem: Moderate severity if not treated.

Counseling/Coordination of care: Discussion regarding impressions, prognosis, risk/benefits, treatment options, follow-up, patient education: 10-15 minutes.

Medical Decision-Making: Limited diagnoses w/ moderate amount of data to be reviewed, moderate complexity of decision making and moderate morbidity.

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06-05-08

4 - Healthcare informati...

72 years old.

Patient had an episode of hives last week which has resolved with OTC antihistamines.
Patient has been paying attention to prudent diet and regular exercise with resulting blood sugar range 90-104 with weight loss.
Patient is considered about her medications and says that she is taking two NSAIDs and two SSRIs. It turns out that she had some old bottles of Prozac and has been taking Lexapro but has found that the Lexapro is causing a side effect. She takes Diclofenac but has reserved Indocin for when she has gout, otherwise, she is doing well on HCTZ, Atenolol, Zocor, Zestril, Digoxin, Valium prn, Midrin prn, and Prilosec prn.
Exam: 18 61 137/78.
Patient pleasant, cooperative, talkative; sits comfortably in chair. Brief exam unchanged from previous visit.

Impression:	Type 2 Diabetes	Insomnia
	Non-Insulin Dependent	Hives
	Diabetes Well Controlled	

Plan: DC Diclofenac, and continue Indocin for arthritis and gout.
DC Lexapro (intolerant side effect). Continue Prozac 20 mg qd for mood management. Continue other meds unchanged. Other supportive measures including antihistamines for hives which has now resolved with positive feedback. RTC prn. Precautions given for calling/returning w/ positive feedback.
Nature of the presenting problem: Moderate severity if not treated.
Counseling/Coordination of care: Discussion regarding impressions, prognosis, risk/benefits, treatment options, follow-up, patient education: 10-15 minutes.
Medical Decision-Making: Limited diagnoses w/ moderate amount of data to be reviewed, moderate complexity of decision making and moderate morbidity.

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5/22/08

4 - Healthcare inf...

72yo

April 2008 comprehensive metabolic panel within normal limits except glucose 125. Glycohemoglobin 8.3. Cholesterol 136, triglyceride 118, HDL 31, LDL 81. WBC 8.4, HCT 43, PLT 226. TSH within normal limits.

Patient is happy to report that her blood sugars have ranged 100-129, asymptomatic; and that she never did start taking metformin 500 mg b.i.d.

Patient reports that she was shopping in a scooter at Wal-Mart when she was bumped by a worker. This is significantly jarred her, and ever since that time, she has been complaining of bilateral hip discomfort radiating into the thighs. She has bilateral hip replacements, and says that these have been quite uncomfortable ever since. Complete Review of Systems otherwise minimized.

Exam: 16 54 145/89 (patient refuses weight).

Patient ambulates easily with a cane with her usual gait. Brief exam unchanged from previous visit.

Impression: Type 2 Diabetes Controlled/Non-Ins-Dependent; Musculoskeletal Bilateral Hip Pain Status Post Bilateral Hip Replacements

Plan: Encouraged the patient to continue with her current diet, exercise, and weight loss program with positive feedback.

She is having significant relief of her hip pain with Naprosyn 500 mg b.i.d. Precautions given for calling/returning with positive feedback.

RTC one month for interval assessment and blood sugar diary review. We will draw her glycohemoglobin test again in July 2008; and if it is poorly controlled, then we will initiate metformin therapy. Further evaluation and treatment as indicated.

Nature of the presenting problem: Moderate severity if not treated.

Counseling/coordination of care: Discussion regarding impressions, prognosis, risk/benefits, treatment options, follow-up, patient education: 10-15 minutes.

Medical Decision-making: Limited diagnoses with moderate amount of data to be reviewed; moderate complexity of decision-making and moderate morbidity.

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04-23-08

4 - Healthcare informati...

72 years old.

Patient went to see her new great grandchild in Texas earlier this month and has an convoluted family stress story to tell. Her son is divorced and his ex wife is now involved in a lesbian relationship, but unfortunately her lover went back to her husband causing family turmoil in Texas regarding the grandchildren and now the great grandchild. The patient also has significant delays in her travels and that her flights were delayed for 2 days due to cancellations across the country. Needless to say, she has been quite stressed and feels that this has contributed significantly to elevated blood sugars despite her good efforts with prudent diet and diabetic lifestyle. Her blood sugars range 75-167. Because of her anxiety she has had some insomnia. She also mentions worsening to urinary incontinence and gout incidentally. She would like refills on blood pressure medicine. Pt denies any chest pain, shortness of breath, palpitations, racing heart, and skipped beats.

Exam: 16 59 130/60. (Patient refuses weight).

Patient pleasant, cooperative, talkative; sits comfortably in chair. Brief exam unchanged from previous visit.

Impression:	Adjustment Reaction	Diet Controlled Type 2 Diabetes
	Insomnia	Gout
	Hypertension	UTI ~~Result~~ Resolved

Plan: Restart Valium 10 mg qhs for insomnia since she has not had good luck with Xanax helping with insomnia. Refilled Allopurinol, Indocin, and Zestril. RTC 1 month for interval assessment. Precautions given for calling/returning w/ positive feedback.

Nature of the presenting problem: Moderate severity if not treated.

Counseling/Coordination of care: Discussion regarding impressions, prognosis, risk/benefits, treatment options, follow-up, patient education: 10-15 minutes.

Medical Decision-Making: Limited diagnoses w/ moderate amount of data to be reviewed, moderate complexity of decision making and moderate morbidity.

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03-27-08

4 - Healthcare informatio...

72 years old.

Patient is upset with her pharmacy and is switching all medicines to a different one because of continued difficulties. She is doing well on current medications only complaining that she has racing thoughts that keep her awake at night and disrupt her sleep onset. She also has nocturia x2. Pt denies urinary burning, pain, hesitancy, frequency, urgency, odor, & residual sensation. She says that she has been feeling tired lately. Complete Review of Systems otherwise minimized.

Exam: 18 67 134/71 (Refuses weight).

Patient ambulates independently with a cane, complaining about the snow and irregular walking surfaces outside. Abdomen is soft, flat, NT to palp, w/ no HSM nor masses; BS+. No CVAT. Urine dipstick strongly positive for glucose and nitrates. Random Accu-check 248.

Impression:	UTI	New onset type 2 diabetes
	Fatigue	Chronic renal failure

Plan: Start Bactrim DS bid x1w for UTI.

Refilled Prozac, HCTZ, Atenolol, Zocor, Zestril, Digoxin, Diclofenac, Ambien, and started Xanax 0.5 mg qhs to quite her racing thoughts.

Provided multiple handouts on diabetes, strongly encouraging to her to check blood sugars on a regular basis. Sent her for FLP, CMP, CBC, and TSH. RTC 2 weeks for interval assessment and blood sugar diary review. Precautions given for calling/returning w/ positive feedback. Further evaluation / treatment as indicated. RTC prn.

Nature of the presenting problem: Moderate severity if not treated.

Counseling/Coordination of care: Discussion regarding impressions, prognosis, risk/benefits, treatment options, follow-up, patient education: 15-25minutes.

Medical Decision-Making: Multiple diagnoses w/ extensive amount of data to be reviewed, moderate complexity of decision making and moderate morbidity.

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11-14-07

4 - Healthcare inf...

71 years old

Pt says that Prozac has done a nice job of smoothing her mood at 20mg qd. She worries though that it may be too sedating for her, because at times she is busy in the morning.
She had itching all over to the point that she is scratching herself to pieces and would like a medicine for itching.
Pt complains of insomnia saying that she may lie awake for hours at night and would like a medicine for this. She has been on Ambien 12.5mg qhs before, but it left her with some morning residual sedation.
Exam: 20 78 130/76
Cardiopulmonary exam benign. No LE edema. Skin exam is clear.

Impression:	Depression	Insomnia
	Itching	HTN

Plan: Start Allegra 180mg qd for skin itching.
Restart Ambien CR 6.25mg qhs for insomnia. Continue other meds unchanged. Precautions given for calling/returning w/ positive feedback. Further evaluation / treatment as indicated. RTC prn.
Nature of the presenting problem: Moderate severity if not treated.
Counseling/Coordination of care: Discussion regarding impressions, prognosis, risk/benefits, treatment options, follow-up, patient education: 10-15 minutes.
Medical Decision-Making: Limited diagnoses w/ moderate amount of data to be reviewed, moderate complexity of decision making and moderate morbidity.

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10-10-07

4 - Healthcare inf...

71 years old

Ms. 4 - Healt... is having mood swings, depression, anxiety, palpitation, indigestion, insomnia, poor appetite, and feelings of being overwhelmed. This contributes to gastritis which is also worsened by her NSAIDS, which she says helps for arthritis pain. She has been on Prozac in the past, but stopped it in 6/06 because it had lost its effectiveness. She only took Lexapro for a few months, but stopped because of excessive sedation. Since that time she has taken Valium 5mg bid, but says that it has been ineffective at relieving anxiety symptoms.

Her sons accompany her to her visit today confirming many of her complaints at the same time that she says they are supportive, she also admits that they have contributed to a significant amount of stress in her life with there own personal problems. Patient complains of difficulty sleeping, poor interests/hobbies/enjoyment, guilty feelings, poor energy level, poor concentration, poor appetite, poor libido, and depression.

Otherwise the patient is doing well on Atenolol, HCTZ, Zocor, Lisinopril, Digoxin, Diclofenac, and Prilosec. Complete Review of Systems otherwise minimized.

Exam: 16 66 131/88 (pt refuses weight)

Pt is somewhat upset during our visit today. While she describes all the family and mental stresses that she has been experiencing in the last several months.

Impression:	Anxiety/Depression	HTN
	CHOL	Gastritis
	Multiple OA	

Plan: Consent form signed and flu shot administered with no reaction.

I explained to the patient and her sons that the majority of her symptoms maybe related to untreated anxiety/depression and that a restart of Prozac 20-40mg qd would not be unreasonable as a first step to reversing a lot of these symptoms which have recurred. RTC 1 month for interval assessment. Continue other meds unchanged. Precautions given for calling/returning w/ positive feedback. Further evaluation / treatment as indicated.

Nature of the presenting problem: Moderate severity if not treated.

Counseling/Coordination of care: Discussion regarding impressions, prognosis, risk/benefits, treatment options, follow-up, patient education: 10-15 minutes.

Medical Decision-Making: Limited diagnoses w/ moderate amount of data to be reviewed, moderate complexity of decision making and moderate morbidity.

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5/10/2007

4 - Healthcare inf...

71 years old.

EKG from January 2000 sevenths showed atrial fibrillation, but since the patient was put on digoxin she has had no further episodes of irregular heartbeat.

Last month, the patient was complaining of dizziness and seeing flashing lights. She simply has been noticing these bright flashing lights occurring in her vision every now and then, and during simple activities such as shopping. Patient denies any trauma, injuries, or accidents. She went to the eye doctor and had a full eye exam, and there was found to be no specific retinal detachment. She is going back for glaucoma check next week. CAT scan of the head showed no acute intracranial abnormality that would explain her symptoms. She still has some difficulty describing her sensation, but admits that she has been under it a significant amount of stress with her sons, selling her house, and other things. She describes moderate headaches that are associated with these vision changes, occasional nausea, and photophobia. She has never had migraine headaches diagnosed in the past.

April 2007 right knee films showed severe degenerative changes of the knee in the patellofemoral compartment with joint space narrowing and spurring present.

Otherwise the patient is doing well on HCTZ, atenolol, Zocor, Zestril, and Diclofenac. Complete Review of Systems otherwise minimized.

Exam: 18 72 (pulse regular) 147/88 (patient refuses weight)

Patient ambulates with a cane because of DJD knee pain. HEENT and cardiopulmonary exams benign except she has a minimal amount of moisture in the right external auditory canal; there is no associated EAC swelling, erythema, nor odor. She reports having a red, itchy rash under the breasts.

Impression:	Hypertension	Breast Intertrigo
	Hyperlipidemia	Paroxysmal Atrial Fibrillation
	DJD Knee	Tension Headaches

Plan: Start Midrin tabs q.i.d. as needed for severe headaches. Discussed the possibility of migraine headaches, but it seems highly unlikely in this age of patient. There are times that she has symptoms without headache, so it is possible that this may represent migraines without headache, but I feel that is highly unlikely. I reassured the patiem about the benign nature of her exam today, her CAT scan results, and her eye exam. Precautions given for calling/returning with positive feedback. Further evaluation and treatment as indicated.

Start Lotrisone cream to breast intertrigo b.i.d. until clear. Continue other current medications unchanged.

Provided a note indicating that the patient has been seen in the family medicine clinic for multiple medical issues. It is recommended that her daughter-in-law live nearby so that she may attend to the patient's needs in a caregiving way.

Nature of the presenting problem: Moderate severity if not treated.

Counseling/coordination of care: Discussion regarding impressions, prognosis, risk/benefits, treatment options, follow-up, patient education: 10-15 minutes.

Medical Decision-making: Limited diagnoses with moderate amount of data to be reviewed; moderate complexity of decision-making and moderate morbidity.

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W Kirk Harris, MD

Northwest Radiology Group, LLC

500 Lilly Road NE, Suite 160 * Olympia, WA 98506 * Phone: (360) 413-8383 Fax: (360) 413-8323

4 - Healthcare information readily ide...

HEAD CT without IV contrast
Date of exam: April 19, 2007

4 - Healthc...
3 - Healthcare In...

Patient #: 04038592
Ticket #: 74520

CLINICAL INDICATION: 71-year-old female with dizziness and experience of seeing flashing lights.

COMPARISON STUDIES: None.

TECHNIQUE: 5 mm thick helical CT scans through the brain from skull base to vertex. 2 mm thick helical CT scans are performed through the region of the sella turcia. No intravenous contrast agent given because patient refused this.

FINDINGS: Ventricles, cisterns and sulci are within normal limits for patient's age. No midline shift, mass or mass effect. No intraparenchymal hemorrhage identified. No extraaxial fluid collection or hematoma seen.

Basal ganglia appear normal. Midbrain, upper cord and posterior fossa unremarkable. Region of the sella turcica suggests a partial empty sella. I do not see a suprasellar mass. Region of the cavernous sinus and circle of Willis appears grossly unremarkable.

Skull base and bony calvarium intact. Orbits, paranasal sinuses and mastoid air cells appear gross clear. Internal auditory canals do not appear expanded. I do not see a mass in the region of the region of the cerebellopontine angles.

IMPRESSION:

1. No acute intracranial abnormality identified.
2. Probable partial empty sella.
3. No finding explains patient's symptoms.

WK Hpc

Randall M Patten, MD
Radiologist

REFERRING PHYSICIAN: W Kirk Harris, MD
Thank you for this referral. For consultation with the radiologist, please call 360-413-8383.
rm

DICTATED BUT NOT REVIEWED

FAXED 4/20/07

4-30-07

Northwest Radiology Group, LLC

500 Lilly Road NE, Suite 160 * Olympia, WA 98506 * Phone: (360) 413-8383 Fax: (360) 413-8323

4 - Healthcare information readily identifi...

RIGHT KNEE X-RAY SERIES
Date of examination: 04/06/2007

3 - Healthcare Int...

Patient #: 04038592
Ticket #: 73742

CLINICAL INDICATION: Ongoing right knee pain for the last five years in a 71-year-old woman. No known acute injury.

FINDINGS: Two views are supplied showing no acute fracture or dislocation. No definite joint effusion. No discrete focal osseous lesion.

There is spiking of the tibial spines with femoral tibial spurring but no obvious femoral tibial joint space narrowing on these nonweightbearing views. There is marked patellofemoral joint space narrowing and spurring and there is increased density in the region of the joint space which could represent either chondrocalcinosis or small intraarticular loose bodies. No periarticular calcifications or soft tissue mass.

Along the distal medial metaphysis of the femur, there appears to be mild cortical expansion in a somewhat bulbous appearance of the distal bone. I believe this is likely an abnormal stress reaction or normal variation. I do not see any osseous destruction or focal neoplasm. There is slight resultant valgus angulation of the knee joint.

IMPRESSION: There appears to be fairly severe degenerative changes of the knee predominantly in the patellofemoral compartment. The preference of patellofemoral joint space narrowing and spurring is a finding associated with calcium pyrophosphate crystal deposition disease (CPPD). No acute bony abnormality is shown.

Randall M. Patten, MD
Radiologist

WKHpc

REFERRING PHYSICIAN: W Kirk Harris, MD
Thank you for this referral. For consultation with the radiologist, please call 360-413-8383.
db

4/11/07

FAXED 4/11/07

0108

W. Kirk Harris, MD
Littlerock Family Medicine

6981 Littlerock Rd SW #101
Tumwater, WA 98512

Tel: 360-943-3633
Fax: 360-528-4643

4/3/07

4 - Healthcare inf...

71yo

The patient is c/o worsening right knee pain that awakens her at night. She has not rested but she is also not taken Indocin as prescribed. She has only been using prn.
She has significant right third toe gout pain and her tophus is coming out of the skin.
The patient generally feels unwell c/o acid peptic complaints. She takes Alka Seltzer every day and says that it helps but she still has some nausea and dizziness. Valium helps with anxiety.
Exam: 18 74 126/64
Knee exam: No bruising, discoloration, deformity, or swelling. Nontender/full ROM. Ligament testing shows no significant/abnormal laxity. No joint line nor patella manipulation tenderness.

Impression:	Right knee DJD	Gastritis
	Gout	Anxiety

Plan: Encouraged the patient to take Indocin 25mg tid. Start Prilosec 20mg qd for gastritis. Start Allopurinol 100mg qd for gout
Sent the patient for right knee films. Precautions given for calling/returning w/ positive feedback. Further evaluation / treatment as indicated. RTC prn. Nature of the presenting problem: Moderate severity if not treated.
Counseling/Coordination of care: Discussion regarding impressions, prognosis, risk/benefits, treatment options, follow-up, patient education: 10-15 minutes.
Medical Decision-Making: Limited diagnoses w/ moderate amount of data to be reviewed, moderate complexity of decision making and moderate morbidity.

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2/13/07

4 - Healthcare inf...

71yo

Ms. 4 - Healt... is taking Digoxin 0.25mg qd and is happy to report that she has had no more episodes of palpitations attributable to atrial fibrillation. She has had no dizziness or side effect on the medication. She has no more leg swelling and no more SOB.

She continues to c/o multiple joint arthritis saying that Indocin did not work as well as Diclofenac. Complete Review of Systems otherwise minimized.

Exam: 18 76 129/72

Cardiopulmonary exam benign. No LE edema.

Impression: Paroxysmal atrial fibrillation Right knee DJD

Plan: Refilled Digoxin 0.25mg qd for PAF. Continue other meds unchanged. Precautions given for calling/returning w/ positive feedback. Nature of the presenting problem: Moderate severity if not treated. Counseling/Coordination of care: Discussion regarding unpressions, prognosis, risk/benefits, treatment options, follow-up, patient education: 10-15 minutes.

Medical Decision-Making: Limited diagnoses w/ moderate amount of data to be reviewed, moderate complexity of decision making and moderate morbidity.

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1/30/07

4 - Healthcare inf...

70yo

1/07 CMP WNL except BUN 25 and Creatinine 1.8. WBC 8, HCT 44, PLT 274, TSH WNL.
For the past several days the patient has had exquisite discomfort in the right great toe radiating into the medial foot. This pain was so significant that she had to hold her foot out from under the seats. She has had some right foot swelling.
Exam: 20 74 147/74 (Pt refuses weigh in)
She has a 5x7mm tophus on the right third toe. The right great toe is somewhat reddened but not particularly hot.
Impression: Right great toe gout Right third toe tophus
Plan: Start Indocin 25mg tid. If she does not have improvement with this then we will consider Colchicine or Allopurinol. Precautions given for calling/returning w/ positive feedback. Further evaluation / treatment as indicated. RTC prn. Nature of the presenting problem: Moderate severity if not treated.
Counseling/Coordination of care: Discussion regarding impressions, prognosis, risk/benefits, treatment options, follow-up, patient education: 5-10 minutes.
Medical Decision-Making: Single diagnosis w/ moderate amount of data to be reviewed, low complexity of decision making and moderate morbidity.

W Kirk Harris, MD

CARE
MEDICAL & REHABILITATION EQUIPMENT

3430 Pacific Avenue SE, Suite A5
Olympia, Washington 98501
Phone: (360) 459-1520
Fax: (360) 570-5775

WHEELCHAIR PRESCRIPTION

Date of Birth: 4 - Healthc...
ICD-9 Code/Diagnosis: 715.09
Estimated Length of Need (months): 99 MONTHS
Lifetime = 99 months DSHS = 1 to 6 months

Face to Face Exam Completed:

Height: 64 Weight: 250

Date: 10/08/2006
Patient: 4 - Healthcare information rea...
HICN # 3 - Healthcare... A

Please confirm the following information:	YES	NO	N/A
Can the patient's mobility deficit be resolved safely with a cane or walker?	☐	X	☐
Will the patient's home environment accommodate the use of a wheelchair?	X	☐	☐
Is the patient able to safely propel a manual wheelchair?	X	☐	☐
Does the patient's caregiver require the use of a manual wheelchair to assist the patient?	☐	X	☐
Does the patient require a lower height because of short stature or to enable the patient to place his/her feet on the ground for propulsion?	☐	X	☐
Is the patient unable to propel a standard wheelchair?	☐	X	☐
Can the patient self propel a lightweight wheelchair?	☐	☐	X
Does the patient engage in frequent activities that cannot be performed in a standard or lightweight wheelchair?	☐	X	☐
Does the patient require a seat width, depth or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair?	☐	X	☐
Is the equipment needed for mobility solely for use outside of the home?	☐	X	☐
How many hours per day does the patient spend in a wheelchair?	10 hours		
Does the patient have sufficient strength and sitting stability to safely operate a power scooter?	☐	☐	X
Does the patient require features that are not available in a scooter, such as special seating and positioning, an alternative control device, or a lower seat transfer height?	☐	☐	X
Is the patient able to safely operate a power wheelchair?	☐	☐	X

Equipment Ordered:
HEAVY DUTY WHEELCHAIR WITH FOOTREST

Physician: DR W KIRK HARRIS MD
Address: 6981 LITTLEROCK ROAD SW STE 101
TUMWATER WA 98512
Phone: 360-943-3633

License #: MD00028579
State ID#: 7901150
UPIN: E29955
Fax: 360-528-4643

Physician Signature

2-16-07
Date

FAXED 2/16/07

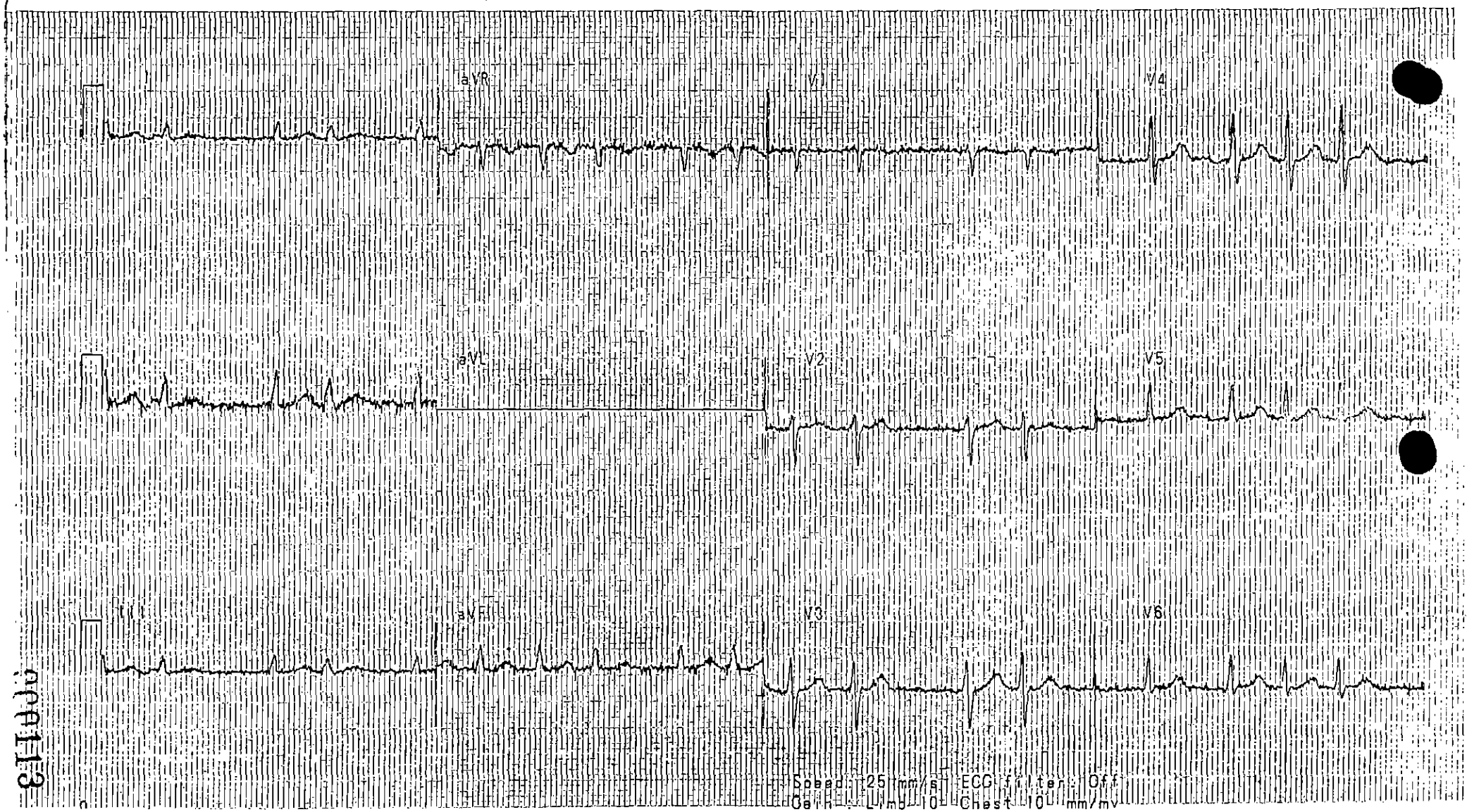
CM-141

000112

ID 931352
Age 70 Sex : Female
Hgt : 53 Wgt : 240
B/P : 100/84 Race: Caucasian
Optn:
Med1: None
Med2: None
Tech: ML Dr. : HARRIS
Site: C Unit: 0
Date: 01/15/07 Time: 13:41

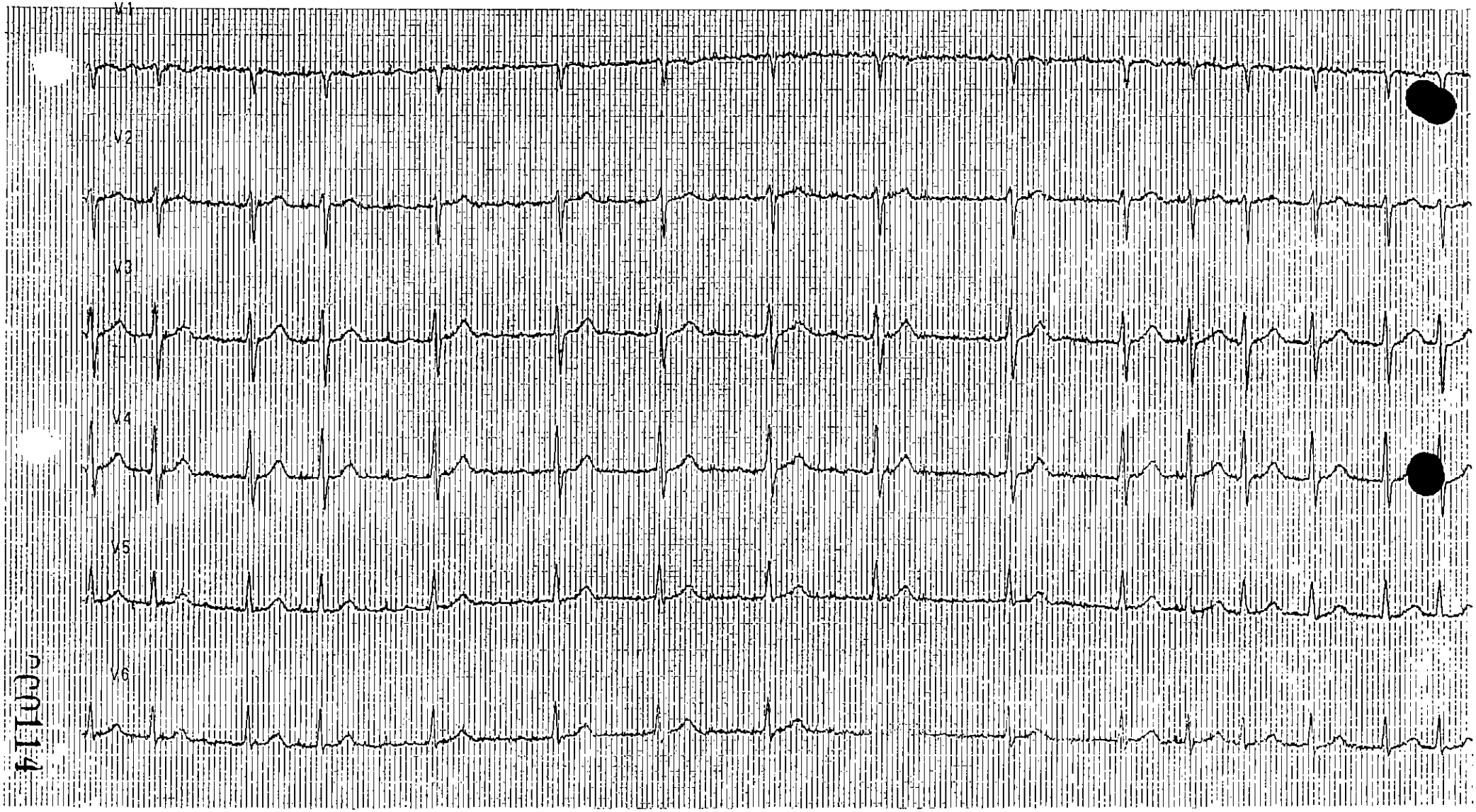
Vent Rate	Durations PR	QRS	QT/QTc	Axes P	QRS	T
107	0	96	328/391	999	55	-32

ATRIAL FIBRILLATION WITH RAPID VENTRICULAR RESPONSE WITH ABERRANT CONDUCTIO OR
VENTRICULAR PREMATUR OMPLEXES
MODERATE ST DEPRESSION [0.05+ MV ST DEPRESSION], PROBABLY DIGITALIS EFFECT
ABNORMAL QRS-T ANGLE [QRS-T A[illegible] 60]
ABNORMAL ECG



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page 1

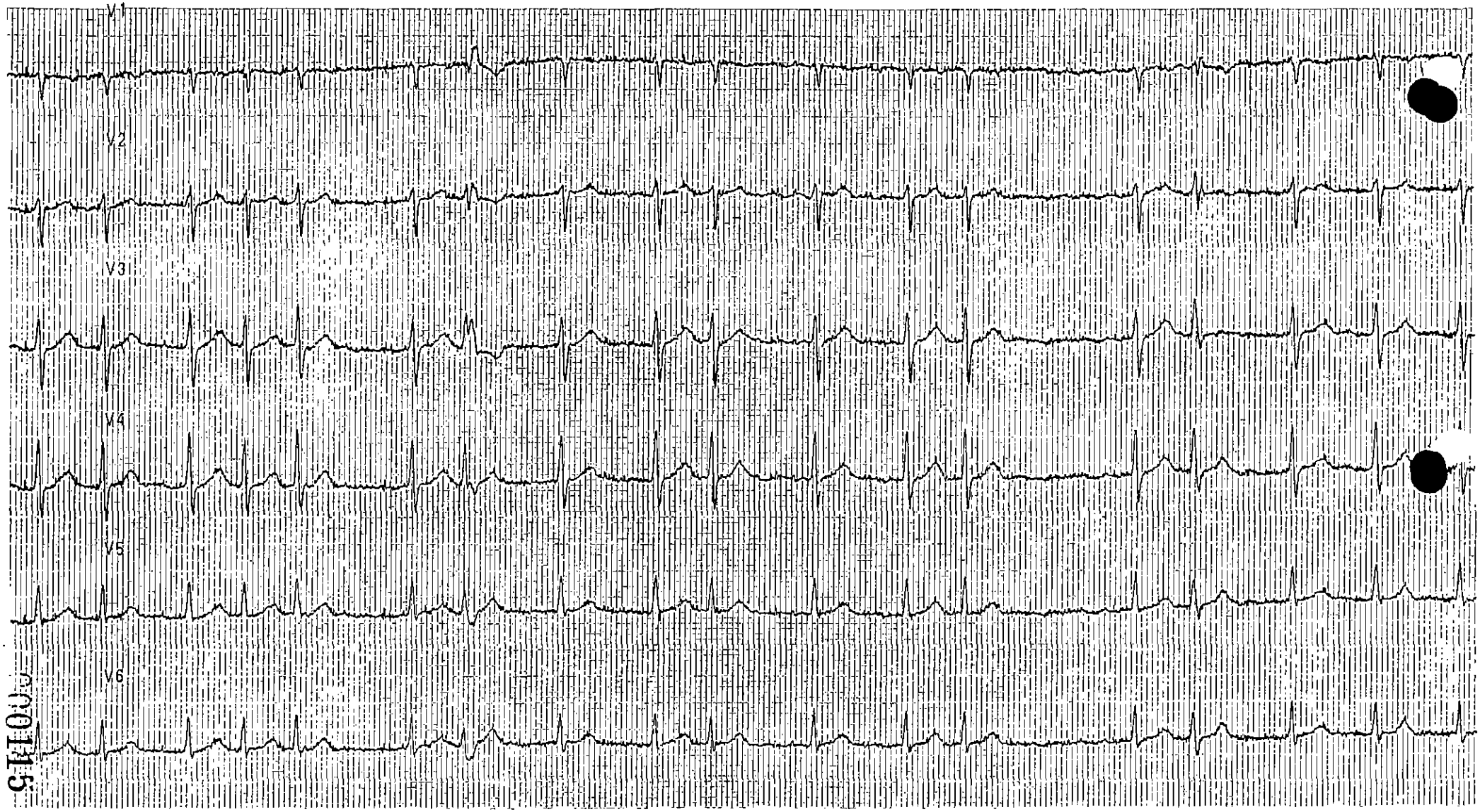


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MADE IN USA

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Gain : Limb 10 Chest 10 mm/mv

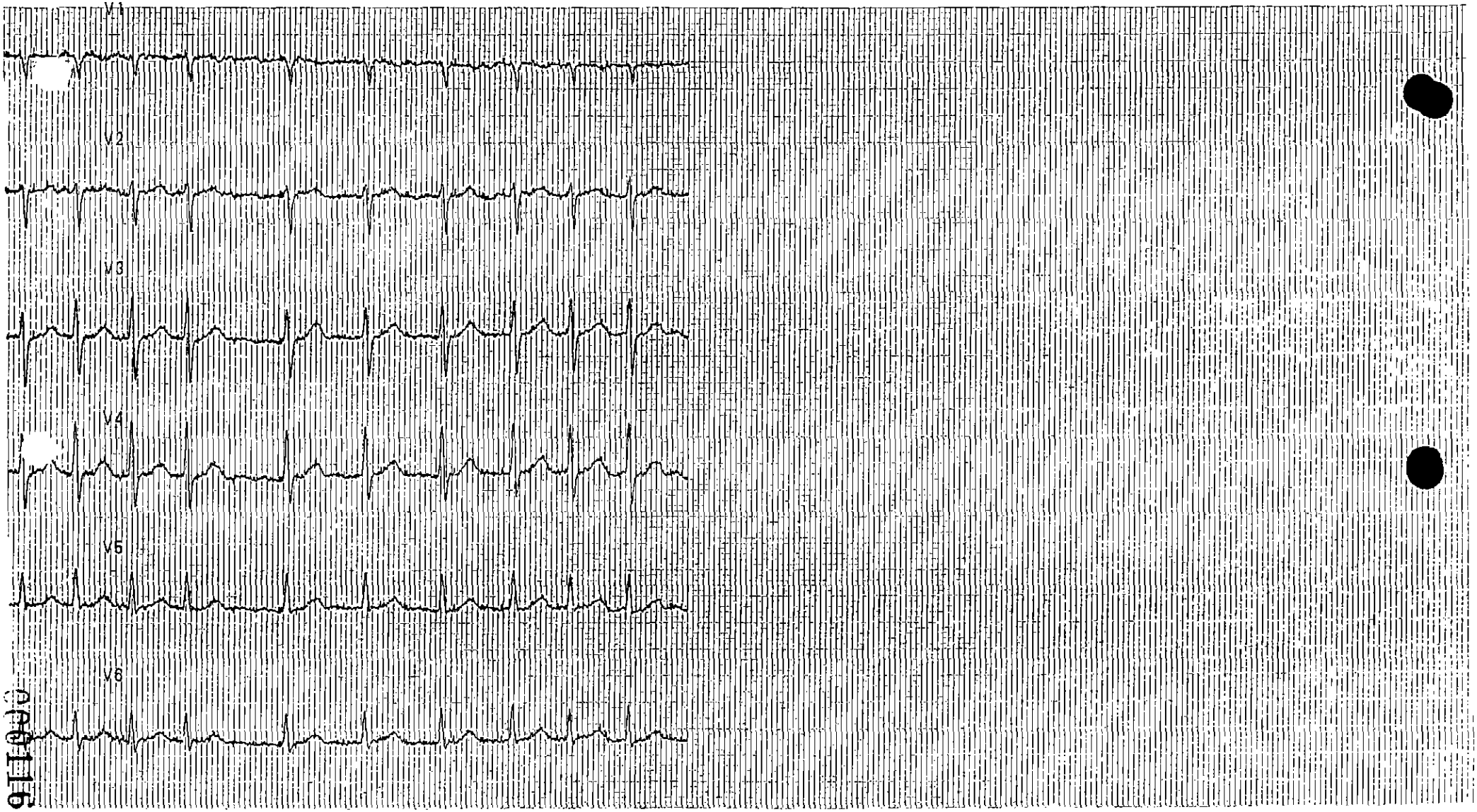
page 2



MADE IN USA

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Gain : Limb 10 Chest 10 mm/mv

page 3



1-8505

MADE IN USA

W. Kirk Harris, MD
Littlerock Family Medicine

6981 Littlerock Rd SW #101
Tumwater, WA 98512

Tel: 360-943-3633
Fax: 360-528-4643

1/15/2007

4 - Healthcare inf...

70 years old.

For the past week, the patient says that she has felt palpitations with some associated dizziness. She denies any specific chest pain, heaviness, or shortness of breath. Blood pressures have been in good control on HCTZ 25 mg q.d., atenolol 50 mg q.d., and Zestril 20 mg q.d.

She has a new swollen spot on her right third toe that she is concerned about. Patient denies any trauma, injuries, or accidents. The spot is only red and slightly swollen, but not hot nor painful. Patient denies any colds, coughs, flus, fevers, chills, sweats, ear pain, sore throat, and dysuria. Pt denies any runny/itchy eyes & nose with sneezing. Patient denies any urinary burning, pain, hesitancy, incontinence, sexual dysfunction, frequency, urgency, nocturia, hematuria, and residual sensation. Patient denies any constipation, diarrhea, or blood in stool. Complete Review of Systems otherwise minimized.

PMH: January 2004. BMP within normal limits. WBC 7, HCT 43, PLT 285.

July 2004 cholesterol 299, triglyceride 257, LDL 209, HDL 39, and LFTs within normal limits on Lescol.

April 2005 cholesterol 218, triglyceride 236, LDL 137, HDL 34.

Exam: 21 71 100/84 (patient refuses weight).

Well nourished, well developed, obese, white female in no acute distress; pleasant, cooperative and talkative. EOMI, PERRLA. TMs clear. Pharynx benign. Teeth in poor repair. No cervical nodes nor JVD. Heart has an irregularly irregular rhythm with no murmur. Lungs CTAT. Abdomen soft, massively obese, nontender to palpation with no HSM nor masses; BS+. Extremities FROM with strong symmetrical pulses throughout; no CCE. EKG shows aurial fibrillation with rapid ventricular response with aberrant conduction and PVCs (rate 107).

Impression:	New Onset Atrial Fibrillation	Hypertension
	Obesity	Hyperlipidemia

Plan: Discussed atrial fibrillation at length with the patient with positive feedback. Start digoxin 0.25 mg q.d. go for rate and rhythm control. Comprehensive metabolic panel, CBC, TSH. Will call patient with results when received. Further evaluation/treatment as indicated.

Start Valium 5 mg b.i.d. p.r.n. anxiety. Precautions given for calling/returning with positive feedback.

Nature of the presenting problem: Moderate severity if not treated.

Counseling/coordination of care: Discussion regarding impressions, prognosis, risk/benefits, treatment options, follow-up, patient education: 10-25 minutes.

Medical Decision-making: Multiple diagnoses with extensive amount of data to be reviewed; moderate complexity of decision-making and moderate morbidity.

This document was created using voice-recognition software.

W Kirk Harris, MD

000117

W. Kirk Harris, MD
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11/16/06

4 - Healthcare inf...

70yo

Ms. 4 - Healt... is doing well on HCTZ, Atenolol, Zocor, Zestril, Diclofenac, and Lexapro but complains that Valium is no longer working for insomnia. She would like to try a different medication.

Pt has been bothered by some malodorous discharge from the right ear canal. This is an ear that she has had surgery on, but she has not had a significant amount of infections with it.

Exam: 20 71 137/77

HEENT and cardiopulmonary exams benign except she has purulence and odor in the right external auditory canal.

Impression:	Right otitis exertema	HTN
	Cholesterol	Depression
	Insomnia	

Plan: Augmentin 500mg bid x 10d.

DC Valium (ineffective for insomnia). Start Ambien CR 12.5mg qhs. Continue other meds unchanged. Consent form signed and flu shot administered with no reaction. **RTC 1mo for interval assessment.**

Precautions given for calling/returning w/ positive feedback. Further evaluation / treatment as indicated.

Nature of the presenting problem: Moderate severity if not treated.

Counseling/Coordination of care: Discussion regarding impressions, prognosis, risk/benefits, treatment options, follow-up, patient education: 10-15 minutes.

Medical Decision-Making: Limited diagnoses w/ moderate amount of data to be reviewed, moderate complexity of decision making and moderate morbidity.

W Kirk Harris, MD

W. Kirk Harris, MD
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9/27/2006

4 - Healthcare inf...

70 years old.

Patient took Lexapro 5 mg q.d. for another month, but then said that she was able to tolerate the 10 mg dose without excessive sedation. She is very pleased with the combination of Valium and Lexapro, and would like to continue these medications. She describes some ongoing family stressors regarding her boys and her sisters, but minimizes these issues.

She's otherwise doing well on HCTZ, atenolol, Zocor, Zestril, and diclofenac. Complete Review of Systems otherwise minimized.

Exam: 22 82 131/63.

Brief exam unchanged from previous visit. Patient has some mild moist eyes, but denies any specific seasonal allergy symptoms.

Impression: Depression — Hypertension
Moist Eyes — Overweight/Deconditioning

Plan: Reassured the patient that her moist eyes are probably simply just a reaction to some mild, seasonal irritant. Precautions given for calling/returning with positive feedback.

Will continue current medicines unchanged, with the patient deciding whether she needs to continue on the 5 mg q.d. of Lexapro or if she can tolerate the 10 mg q.d. dose.. Further evaluation and treatment as indicated.

Nature of the presenting problem: Moderate severity if not treated.

Counseling/coordination of care: Discussion regarding impressions, prognosis, risk/benefits, treatment options, follow-up, patient education: 10-15 minutes.

Medical Decision-making: Limited diagnoses with moderate amount of data to be reviewed; moderate complexity of decision-making and moderate morbidity.

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8/24/06

4 - Healthcare inf...

70yo

Ms. 4 - Healt... says that Lexapro seems to be too strong in that it causes excessive sedation. She is very depressed about her current situation and realizes that she needs an antidepression medicine but just cannot seem to get pas the sedation side effect of this medicine.

She has taken Valium 10mg qhs and says that it helped with sleep for about 5 hours but gives her very vivid dreams. She has not experimented with decreased doses of either of these meds.

Otherwise, she is doing well on HCTZ, Atenolol, Zocor, Zestril, and Diclofenac.

The pt was able to spontaneously speak for about 10-15 minutes straight about her laid back son, Sean, her difficult son, Greg, her 4 grandsons, Greg's ex-wife who has turned lesbian, her alcohol late Air Force Agent Orauge-infected husband who died 2-3 years ago, strange relations with her sisters, etc. The most important of these is that she has moved to this area to be closer to her grandchildren and yet still feels displaced from her more comfortable Southern California home.

Exam: 18 82 140/88

Pt seems somewhat distressed but is able to express her feelings clearly.

Impression:	Depression	HTN
	Adjustment reaction	Hyperlipidemia
	Insomnia	

Plan: Suggested that she takes Lexapro 5mg qd and decrease Valium to 5mg qhs prn insomnia. Continue other meds unchanged. **RTC 1mo for interval assessment.** If she is still having intolerable side effects from these meds, then we will change them to different ones. Precautions given for calling/returning w/ positive feedback. Further evaluation / treatment as indicated. Nature of the presenting problem: Moderate severity if not treated.

Counseling/Coordination of care: Discussion regarding impressions, prognosis, risk/benefits, treatment options, follow-up, patient education: 10-15 minutes.

Medical Decision-Making: Limited diagnoses w/ moderate amount of data to be reviewed, moderate complexity of decision making and moderate morbidity.

W Kirk Harris, MD

W. Kirk Harris, MD
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7/27/06

4 - Healthcare inf...

70yo

7/06 Cholesterol 190, triglyceride 150, HDL 40, LDL 120 on Zocor 40mg qd.
Patient is still somewhat depressed about her husband's death even though it was 2 years ago. She feels that increased dose Prozac 40mg qhs has lost its effectiveness, and she would like to try a different antidepression medicine. She only c/o significant insomnia in that she cannot shut off racing thoughts when she goes to bed. This is not so much a problem with anxiety in the daytime.
Pt has multiple arthritis pains which bother her so significantly that she would like a manual wheelchair. Because of bilateral hip arthritis, she cannot even walk through a grocery store despite increased dose Diclofenac 75mg bid. Complete Review of Systems otherwise minimized.
Exam: 20 80 143/78
Patient pleasant, cooperative, talkative; sits comfortably in chair. Brief exam unchanged from previous visit.

Impression:	HTN	Hyperlipidemia
	Overweight/deconditioning	Depression/insomnia
	Multiple OA	

Plan: DC Prozac (ineffective). Start Lexapro 10mg qd. Samples & Rx provided. Other supportive measures described at length including Valium 10mg qhs for insomnia with positive feedback.
Rx for manual wheelchair (bilateral hip DJD, HTN, hyperlipidemia). **RTC 1mo for interval assessment.**
Nature of the presenting problem: Moderate severity if not treated.
Counseling/Coordination of care: Discussion regarding impressions, prognosis, risk/benefits, treatment options, follow-up, patient education: 10-15 minutes.
Medical Decision-Making: Limited diagnoses w/ moderate amount of data to be reviewed, moderate complexity of decision making and moderate morbidity.

W Kirk Harris, MD

W. Kirk Harris, MD
Littlerock Family Medicine

6981 Littlerock Rd SW #101
Tumwater, WA 98512

Tel: 360-943-3633
Fax: 360-528-4643

6/28/2006

4 - Healthcare inf...

70 years old.

Patient is a pleasant 70 year-old white, Scottish female with a history of hypertension, hyperlipidemia, arthritis, and depression, who is here to establish care. She complains that she has a shortness of breath and dyspnea with exertion, but also adds that she has bilateral hip replacements is still bother her. She has had a mild sore throat, but otherwise denies other mild viral or seasonal symptoms that could be bothering her. She takes OTC antacids as needed for heartburn. She mentions some difficulty sleeping, poor energy level, and depression related to the untimely death of her husband three years ago. She took care of him while he was quite Ill with Agent Orange for three years until he died in 2003. She has recently moved to this area to be close to her two sons and four grandsons, but has found the transition a bit difficult. She is been on Prozac 20 mg q.d. for two to three years, but feels like the effect has been lost. Although she does not have significant hip discomfort, she still walks with a cane only for reassurance. Patient denies any colds, coughs, flus, fevers, chills, sweats, ear pain, sore throat, and dysuria. Pt denies any runny/itchy eyes & nose with sneezing. Patient denies any chest pain, shortness of breath, palpitations, racing heart, and skipped beats. Patient denies any urinary burning, pain, hesitancy, incontinence, sexual dysfimction, frequency, urgency, nocturia, hematuria, and residual sensation. Patient denies any constipation, diarrhea, or blood in stool. Complete Review of Systems otherwise minimized

PMH: Left hip replacement surgery 2002. Right hip replacement surgery 2004 was followed by the complication of renal failure; ever since that time, the patient has not felt "completely right."

Medications: HCTZ 25 mg q.d., [illegible] 50 mg q.d., Zocor 40 mg q.d., Zestril 20 mg q.d., Prozac 20 mg q.d., diclofenac 75 mg q.d. NKDA.

Exam: 18 76 134/96 (patient refuses weight)

Well nourished, well developed, obese, white female in no acute distress; pleasant, cooperative and talkative. EOMI, PERRLA. TMs clear. Pharynx benign. Teeth in for repair with many missing and carious teeth. No cervical nodes nor JVD. Heart regular rhythm with no murmur. Lungs CTAT. Abdomen soft, flat, nontender to palpation with no HSM nor masses; BS+. Extremities FROM with strong symmetrical pulses throughout; no CCE.

Impression:	Hypertension	Hyperlipidemia
	Overweight/Deconditioning	Depression/Bereavement
	Multiple Arthritis	Adjustment Reaction

Plan: Increase Prozac to 40 mg q.h.s. She says this medication is somewhat sedating for her, and so we will use that side effect to her advantage to improve her sleep. Will also increase the dose in an attempt to recover some of her depression symptoms. If this is unsuccessful, then we will try different medicine altogether.

Increase diclofenac to 75 mg b.i.d. for maximum anti-arthritis effect. Other medications refilled unchanged.

Completed a handicapped application sticker for her.

Sent her for fasting lipid profile to check on Zocor effectiveness. Precautions given for calling/returning with positive feedback. Further evaluation and treatment as indicated. RTC one month for interval assessment. Will pursue other health maintenance/patient education issues at the next visit.

Nature of the presenting problem: Moderate severity if not treated.

Counseling/coordination of care: Discussion regarding impressions, prognosis, risk/benefits, treatment options, follow-up, patient education: 10-15 minutes.

Medical Decision-making: Limited diagnoses with moderate amount of data to be reviewed; moderate complexity of decision-making and moderate morbidity.

This document was created using voice-recognition software.

W Kirk Harris, MD

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION
PO Box 47866, Olympia, WA 98504-7866

July 18, 2011

6 - Identity - Whistlebl...

COPY

RE: William K. Harris, MD
Case No. 2011-157968MD

Dear Ms. 6 - Iden...:

Thank you for your recent letter in which you express concerns regarding medical care provided by William K. Harris, MD. Your complaint has been assigned case number 2011-157968MD.

Your complaint will be investigated to determine if a violation of the Uniform Disciplinary Act, RCW 18.130.180, Unprofessional Conduct, has occurred. If you have any additional information pertaining to your complaint, please forward it along with a copy of this letter to me at the address listed below. Please understand that you may not hear from us during the investigation. If we need additional information from you, one of the Commission's investigators will contact you.

Enclosed for your information is the brochure, *What Happens Next?* along with a copy of RCW 18.130.180, the statute that identifies Unprofessional Conduct. Once the investigation is complete, a panel of the Medical Quality Assurance Commission will review the facts of the case and make a decision. You will be notified in writing of the decision.

Thank you for bringing your concerns to the attention of the Medical Quality Assurance Commission. If you have any questions or need additional information, please call me at 360-236-2770.

Sincerely,

James H. Smith, Chief Investigator
Medical Quality Assurance Commission
PO Box 47866
Olympia, WA 98506-7866

Enclosures: What Happens Next?
RCW 18.130.180

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION
PO Box 47866, Olympia, WA 98504-7866

July 18, 2011

6 - Identity - Whistlebl...

COPY

RE: William K. Harris, MD
Case No. 2011-157968MD

Dear Ms. 6 - Iden...:

Washington state law, RCW 43.70.075, pertains to the "Whistleblower Law" which requires that the identity of a complainant/whistleblower who complains in good faith to the Department of Health about improper quality of care by a health care provider shall be kept confidential. In some instances, particularly in your case, where you are the consumer of care complaining against a provider, an investigation cannot proceed without disclosure of your identity to the particular provider. This is so the provider can respond appropriately to the allegations of your complaint and provide records specific to your complaint.

This investigation and/or action is contingent upon the disclosure of your identity to the provider. Should you desire this investigation to proceed, your voluntary authorization in the form of an Authorization to Release Complainant's Name will be necessary. I have enclosed this form for your signature, along with a postage paid envelope for its return. Once your waiver is received, your identity will be released solely for the purposes of investigation and adjudication as necessary. Your identity will be protected in all other instances and will not be released in response to public disclosure requests. ***Your signed waiver is due back to this office no later than August 1, 2011.***

If you have any questions, please contact me at (360) 236-2770.

Thank you for your cooperation.

Sincerely,

James H. Smith, Chief Investigator
Medical Quality Assurance Commission
Medical Investigations
PO Box 47866
Olympia, WA 98504-7866

Attachments: Return Envelope
Waiver of Confidentiality of Identity

COPY

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION
MEDICAL INVESTIGATIONS
* * * * *

AUTHORIZATION TO RELEASE COMPLAINANT'S NAME PURSUANT TO RCW 43.70.075

RCW 43.70.075 provides in part: "The identity of a whistleblower who complains, in good faith, to the Department of Health about the improper quality of care by a health care provider, or in a health care facility, ... shall remain confidential."

I understand that my identity is confidential pursuant to RCW 43.70.075 unless waived.

By signing this document, I waive my right to confidentiality and authorize the Department of Health to release my identity to **William K. Harris, MD,** and to other persons who are reasonably necessary to the investigation, and for use in any subsequent administrative proceeding regarding my complaint. I understand that my identity will not be released for any other purpose.

APPROVAL OF CONFIDENTIALITY WAIVER

For the sole purpose of investigating my complaint and pursuing disciplinary/adverse action proceedings, I hereby waive confidentiality and consent to the release of my identity.

Signature:_____ **Printed name:** _____
Please include middle initial
Date:_____
Home Phone:_____ **Date of birth:** _____
Day Phone:_____ *PLEASE RETURN NO LATER THAN August 1, 2011.*

DENIAL OF CONFIDENTIALITY WAIVER

I refuse to waive my right to confidentiality and deny consent to the release of my identity. I understand this denial may impair the Department of Health's ability to pursue investigation of this matter and any disciplinary/adverse actions.

Signature:_____
Date:_____
Home Phone:_____
Day Phone:_____

CASE #: 2011-157968MD
RESPONDENT: William K. Harris, MD

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION
PO Box 47866, Olympia, WA 98504-7866

August 2, 2011

6 - Identity - Whistleblowe...

Re: William K. Harris, MD
Case No. 2011-157968MD

COPY

Dear Ms. 6 - Identit... :

This letter concerns the complaint you recently filed against William K. Harris, MD.

Washington State RCW 43.70.075 pertains to the "Whistleblower Law" that requires that the identity of a complainant/whistleblower who complains in good faith to the Department of Health about improper quality of care by a health care provider shall be kept confidential. In some instances, particularly in your case, where you are the consumer of care complaining against a provider, investigation cannot proceed without disclosure of your identity to the particular provider. This is so the provider can respond appropriately to the allegations of your complaint and provide records specific to your case.

This investigation and/or action is contingent upon the disclosure of your identity to the provider. Should you desire this investigation to proceed, your voluntary authorization in the form of a Waiver of Confidentiality of Identity will be necessary. An original request for release was made on **July 18, 2011**, when your complaint was received. As of this date the requested releases have not been received. I have enclosed a second set of forms for your signature, along with a postage paid envelope for their return. When your waiver has been obtained, your identity will be released solely for purposes of investigation and adjudication, as necessary. If the request is not returned by **August 10, 2011**, the case files will be forwarded to the Medical Quality Assurance Commission for closure without investigafion. If you have any further questions or if I may be of assistance to you, please do not hesitate to call me at (360) 236-2770. Thank you for your cooperafion.

If you do not intend to go forward with this investigation, please sign the denial portion of the whistleblower waiver form and return it to this office.

Respectfully,

James H. Smith, Chief Investigator
Medical Quality Assurance Commission

Attachments: Return Envelope
Waiver of Confidentiality of Idenfity

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION
MEDICAL INVESTIGATIONS
*****

COPY

AUTHORIZATION TO RELEASE COMPLAINANT'S NAME PURSUANT TO RCW 43.70.075

RCW 43.70.075 provides in part: "The identity of a whistleblower who complains, in good faith, to the Department of Health about the improper quality of care by a health care provider, or in a health care facility, ... shall remain confidential..."

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Date:_____ **Please include middle initial**
Home Phone:_____ **Date of Birth:** _____
Day Phone: _____ ***PLEASE RETURN NO LATER THAN August 10, 2011***

DENIAL OF CONFIDENTIALITY WAIVER

I refuse to waive my right to confidentiality and deny consent to the release of my identity. I understand this denial may impair the Department of Health's ability to pursue investigation of this matter and any disciplinary/adverse actions.

Signature:_____
Date:_____
Home Phone:_____
Day Phone:_____

CASE #: 2011-157968MD
RESPONDENT: William K. Harris, MD

TO: Jim

DATE: 8/2 TIME: 12:40

FROM

OF

BEST TIME TO CALL BACK

MESSAGE:

Joyce Tuitele
360-915-7733
#157968
WILLIAM K. HARRIS MD

12:53 is sending 9 pages of additional info & addition Letter THANKS DHS

- ☐ Called You
- ☐ Returned Your Call
- ☐ Will Call Again
- ☐ Please Call
- ☐ Wants to See You
- ☐ Was Here To See You

AREA CODE PHONE NUMBER EXTENSION

AREA CODE FAX NUMBER

SF 8023 12/94 * * I

A Message For You

INITIALS

RECEIVED

AUG 03 2011

DEPARTMENT OF HEALTH
MEDICAL COMMISSION

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION
MEDICAL INVESTIGATIONS

* * * * *

AUTHORIZATION TO RELEASE COMPLAINANT'S NAME
PURSUANT TO RCW 43.70.075

RCW 43.70.075 provides in part: "The identity of a whistleblower who complains, in good faith, to the Department of Health about the improper quality of care by a health care provider, or in a health care facility, ... shall remain confidential."

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APPROVAL OF CONFIDENTIALITY WAIVER

For the sole purpose of investigating my complaint and pursuing disciplinary/adverse action proceedings, I hereby waive confidentiality and consent to the release of my identity.

Signature 6 - Identity - Whistleblower and whistleblower's healthcare infor... **Printed name:** 6 - Identity - Whistleblower and whistleblower's healthcare information - R...
Date: 8/1/11 Please include middle initial
Home Phone: 6 - Identity - Whistleblower and whistleblower'... **Date of birth:** 6 - Identity - Whistleblower an...
Day Phone: SAME
PLEASE RETURN NO LATER THAN August 1, 2011

DENIAL OF CONFIDENTIALITY WAIVER

I refuse to waive my right to confidentiality and deny consent to the release of my identity. I understand this denial may impair the Department of Health's ability to pursue investigation of this matter and any disciplinary/adverse actions.

Signature:_____
Date:_____
Home Phone:_____
Day Phone:_____

CASE #: 2011-157968MD
RESPONDENT: William K. Harris, MD

129

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION
MEDICAL INVESTIGATIONS
* * * * *

RECEIVED
AUG 11 2011
DEPARTMENT OF HEALTH
MEDICAL COMMISSION

AUTHORIZATION TO RELEASE COMPLAINANT'S NAME PURSUANT TO RCW 43.70.075

RCW 43.70.075 provides in part: "The identity of a whistleblower who complains, in good faith, to the Department of Health about the improper quality of care by a health care provider, or in a health care facility, ... shall remain confidential..."

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APPROVAL OF CONFIDENTIALITY WAIVER

For the sole purpose of investigating my complaint and pursuing disciplinary/adverse action proceedings, I hereby waive confidentiality and consent to the release of my identity.

Signature: 6 - Identity - Whistleblower and whistleblower's healthcare in... **Printed name:** 6 - Identity - Whistleblower and whistleblow...
Date: 6 - Identity - Whistleblow... **Please include middle initial**
Home Phone: 6 - Identity - Whistleblower and whistleblow... **Date of Birth:** 6 - Identity - Whistleblower and w...
Day Phone: _____ ***PLEASE RETURN NO LATER THAN August 10, 2011***

DENIAL OF CONFIDENTIALITY WAIVER

I refuse to waive my right to confidentiality and deny consent to the release of my identity. I understand this denial may impair the Department of Health's ability to pursue investigation of this matter and any disciplinary/adverse actions.

Signature:_____
Date:_____
Home Phone:_____
Day Phone:_____

CASE #: 2011-157968MD
RESPONDENT: William K. Harris, MD

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION
PO Box 47866, Olympia, WA 98504-7866

July 18, 2011

William K. Harris, MD
6981 Littlerock Rd
Ste 101
Tumwater, WA 98501

COPY

SUBJECT: Case No: 2011-157968MD

Dear Dr. Harris:

The purpose of this letter is to inform you that the Medical Quality Assurance Commission received a report concerning an allegation of unprofessional conduct as defined in RCW 18.130.180(4), the Uniform Disciplinary Act. RCW 18.130.050, of the Uniform Disciplinary Act, authorizes the Medical Quality Assurance Commission to investigate complaints of unprofessional conduct.

A preliminary investigation to gather the facts will be conducted by a Health Care Investigator from the Medical Quality Assurance Commission, Medical Investigations Unit. The investigator will contact you as soon as possible during the investigation if a statement or other information from you is required.

Please note that the Medical Quality Assurance Commission is bound by statute to comply with two different laws, which may seem to confiict. The first requires that we immediately notify a practitioner that a complaint has been filed. ***The second, the whistleblower law RCW 43.70.075, prohibits us from releasing the name of the complainant or any specific details about the report which could identify the complainant until we have received a signed waiver authorizing us to do so. We are sensitive to the fact that it can be very disconcerting to know a complaint has been filed against you, but not know any details about it. Therefore, once the waiver has been obtained, an investigator will contact you as soon as possible and all issues will be discussed as fully as allowed by law so that you will have an opportunity to respond.*** In a very small percentage of cases, a statement from you will not be required and no investigator will contact you.

You may submit a written statement about the complaint at any time, however, you may choose to wait until after you have been contacted by an investigator and advised of the nature of the complaint. You may consult with legal counsel at your expense prior to making a statement. Any statement that you make may be used in an adjudicative proceeding concerning this case. If the Commission receives any inquiries about the status of your license while this case is still open, only the existence of a complaint will be disclosed. Once the Investigation and case review process has been completed, the case wili either be closed or acted upon. The contents of the closed case file, including any statements submitted by you, will be subject to release according to Washington's public disclosure laws. Most public disclosure requests come from insurance companies and employers.

We have enclosed our informational brochure What Happens Next? along with a copy of RCW 18.130.180 Unprofessional Conduct. Please be aware that this process can take three to six months and in some cases longer. If you have questions, please contact me at 360-236-2770.

Respectfully,

James H. Smith, Chief Investigator
Medical Quality Assurance Commission

Enclosure: What Happens Next, RCW 18.130.180

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE COMMISSION
PO Box 47866, Olympia, WA 98504-7866

COPY

September 2, 2011

WILLIAM HARRIS MD
6981 LITTLEROCK RD STE 101
TUMWATER WA 98501

Re File #:2011-157968MD

Dear Dr. Harris:

The Medical Quality Assurance Commission has received a complaint alleging that you provided poor care to Joyce Tuitele specific to her heart and her left hip (please refer to the attached redacted copy of the Complaint letter).

The Medical Quality Assurance Commission is the entity within State government with legislated authority and responsibility to assure the delivery of safe health care. Under the provisions of RCW 18.130.050, the Washington State Medical Quality Assurance Commission is empowered to investigate all allegations and complaints to determine whether such allegations are substantiated and to take disciplinary or corrective action, if warranted.

Please be advised this is a preliminary investigation only and no charges have been issued in connection with this investigation.

Under provisions of RCW 18.130.180(8) and WAC 246-919-620 a licensee shall cooperate by providing a full and complete explanation covering the matter under investigation.

The Health Care Information Act, RCW 70.02.050 (2)(a), requires that a health care provider disclose health care information about a patient without patient authorization when the information is needed to determine compliance with state licensure rules or laws.

Under the terms of the laws mentioned, you are asked to provide:

1. A written narrative discussing the above allegations, please discuss the circumstances involved and what, if anything, could have been done differently (refer to the attached redacted copy of the Complaint letter).

2. A single-sided, non-redacted copy of your entire medical record for Joyce W. Tuitele, DOB: 02-10-1936; in addition, please provide copies (on CD if possible) of all pertinent radiographs.

You may consult with and engage an attorney at your expense to represent you in this matter before making your response. Your response may be used if disciplinary action is deemed necessary. If you wish to have an attorney represent you, please have the attorney file a Notice of Representation at the address below.

Please submit your response within fourteen (14) days after receipt of this letter. Mail your response to:

Joy Johnson, BSN, RN, Investigator
Department of Health
Medical Quality Assurance Commission
Medical Investigations
P.O. Box 47866
Olympia, Washington 98504-7866

Thank you for your cooperation.

Respectfully,

Joy Johnson, RN
360-236-2777

Attachments: Copy of the redacted Complaint letter

Washington State Department of Health
Medical Quality Assurance Commission
Intake Coordinator
PO Box 47866
Olympia, WA 98506-7866
Phone: 360.236.2762 Fax: 360.586.4573
E-mail: medical.commission@doh.wa.gov

COPY

RECEIVED
JUN 29 2011
DEPARTMENT OF HEALTH
MEDICAL COMMISSION

Complaint Form

Today's Date: 5/17/11

1. Your Information

Name: [redacted] 6 - Identity - Whistleblower and whistleblower's healthcare information - RCW 42.56.5...

Address: [redacted]

City: [redacted] State: [redacted] Zip: [redacted]

Phone: Home: [redacted] Work: [redacted]

Cell Phone: ( ) SAME E-mail: [redacted]

2. Information about the Physician (MD) or Physician Assistant

Name of Physician (MD) or Physician Assistant: DR KIRK HARRIS

Clinic or Facility: 6981 LITTLE ROCK RD.

Address: 6981 LITTLE ROCK RD SW. SUITE 101

City: TUMWATER State: WA Zip: 98512

3. Patient Information

Full name: [redacted] 4 - Healthcare information readily identifiable to a person - RCW 42.56.360(2) and RCW 70.02...

Date of Birth: [redacted] 4 - Healthcare information readily ide...

Date of incident: ONGOING SINCE 2006

4. Scheduling problems or personality conflicts are usually not within the Commission's ability to take action.

5. Reports involving fee for fee disputes or insurance claims are only investigated if there appears to be fraud involved.

6. Please describe your complaint in the space below. Include the names, title and phone number of any witnesses that were involved in the complaint.

7. Please attach any supporting documentation or additional information you may have.

You may submit a complaint to the Medical Commission by mail, fax or email at:

Medical Quality Assurance Commission
Intake Coordinator
PO Box 47866
Olympia, WA 98506-7866
Fax: .360.586.4573

Please describe your complaint in the space below. Include names, titles and phone numbers of any witnesses. Please attach copies of documents to support your complaint. You may mail, email or fax this form to the Medical Quality Assurance Commission at the physical address, email address, or fax number above. NEGLECT OF MY HEART PROBLEM DIABETES PROBLEM, DEPRESSION ANY PROBLEMS I PUT TO THE DR HE SKIPPED OVER. HE GAVE ME A PILL WHEN I JUST WENT TO the DR I COMPLAINED TO him my family history of heart trouble and survivors my mother & father heart, two sisters one 40yrs one 53yrs old both with aneurisms 3 Sisters with strokes all have high blood pressure angina and stroke I have always been very concerned about my heart. I told the DR I was having a

Please include additional sheets as necessary.

W. Kirk Harris, M.D.
FAMILY MEDICINE

6981 Littlerock RD SW Suite 101
Tumwater, WA 98512
360-943-3633 Tel
360-528-4643 Fax

Termination of Care Letter

4 - Healthcare information readily i...

04/26/2011

Dear 4 - Healthcare inform...,

I regret to inform you that as of today I will no longer be your primary physician. We feel that we are not able to meet your medical needs at this time. We will only attend to emergency needs for the next 30 days.

Please consult the local physician referral service, your county medical society, or the yellow pages of your telephone book as soon as possible so that you may find another physician who will assume responsibility for your care.

Sincerely,

Harris, MD

W. Kirk Harris, MD

6 - Identity - Whistleblo... Statement re: Medical Complaint of Dr. Kirk Harris, MD

I had an issue with heart palpitations for over four (4) years. I was continually concerned and voiced my concerns repeated to Dr. Harris at my medical appointments during this four-year period. Dr. Harris did not address or treat the palpitations issue. This issue progressed to the point where I was so out of breath that I could not walk more than 20 feet without becoming tired, listless, and out of breath. I suffered a severe loss of appetite and fell into depression. I voiced my concerns about these symptoms to Dr. Harris. He still did nothing to address or treat theses concerns. I requested a referral to a cardiologist. He told me that my symptoms were merely a matter of my old age.

Dr. Harris is the only doctor I have ever treated with that did not come into the room to ask me to sit down on the table so he could listen to my chest and lungs with a stethoscope and take my vital signs. I would estimate that my vitals were taken no more than five or six times during the four and one-half years I was his patient.

My prior experience was with my treating physician in California. My vital signs were taken at every office visit. Even if a nurse took my vitals, the Medical Doctor would re-take them.

After my repeated requests to Dr. Harris to refer me for an EKG, he reluctantly agreed in October, 2010. Dr. Harris reported to me that the EKG "was good". However, I insisted on him prescribing more tests for my heart.

I went to Providence St. Peter Hospital of my own accord. I was not referred by Dr. Harris. I was seen by Dr. . He put me through some stress tests and immediately scheduled an angioplasty. He told me that he thought I might have a blockage in the artery, but he was a little doubtful about that, because he thought it was something more. While I was having the angioplasty, Dr. told me that there was no problem with my artery, but he found a problem with my heart valve. He wanted to schedule open-heart surgery as soon as possible. Dr. asked me how long I had had these symptoms. When I told him, "Four and one-half years", he was taken aback. He then asked me if I had ever had a stroke, heart attack. When I answered, "no", he was quite surprised.

Dr. sent Dr. to consult with me the same afternoon. I had open-heart surgery five days later.

I believe I was lucky that with Dr. , I got a doctor that knew what he was doing. He also took me off of my Indomicen prescription that

137 ORIGINAL

Dr. Harris had been prescribing for me for four years. Dr. informed me that Indomicen is very bad for the kidneys. Dr. Harris paid no attention to this issue and never informed me of the risks of long term Indomicen use.

In early 2011, I asked Dr. Harris about the DePuy hip implant recall because I have bilateral hip implants and my right knee was becoming increasingly more painful. I also told Dr. Harris that my balance was off while I walk. I told him that I have to be very cautions that I did not understand the cause of my poor balance issue. Dr. Harris repeatedly put me off in regards to making any recommendations for treatment. I knew my knee pain was the result of a problem with my hip implant and every time I brought up the balance issue and the knee pain to Dr. Harris, he ignored me! After repeatedly requesting an MRI of my hip, he sent me for an X-ray of my knee and told me that I had arthritis of the knee and gave me a prescription for Ocycodone. Dr. Harris much preferred to prescribe pain pills instead of addressing a problem. I asked for a referral to an Orthopaedist, but Dr. Harris ignored me again.

I self-referred myself to Dr. at Olympia Orthopaedics. Dr. X-rayed both hips and my knees. He discovered that my left hip replacement was not aligned properly with my prior right hip replacement, which resulted in my left leg being one-half inch shorter than my right leg. Dr. prescribed a lift for my ieft shoe. I am already seeing improvement in my knee pain.

It is very sand when a patient sees the same doctor for almost five years and is treated with such disregard. I have experienced extreme patient neglect from Dr. Harris. I request that he be investigated and reprimanded for his improper and lack of adequate patient care. I also request that his license to practice medicine be tagged for incompetence. He is more interested in prescribing pain pills than he is in treating his patients.

July 10, 2011

State of Washington
Department of Health
Medical Quality Assurance Commission
P.O. Box 47866
Olympia, WA 98504-7866

RECEIVED
AUG 11 2011
DEPARTMENT OF HEALTH
MEDICAL COMMISSION

Re: William K. Harris, MD
Case No: 2011-157968MD

This will acknowledge and thank you for the recent letter informing me that my complaint is being investigated. Thank you for appreciating the seriousness of my concerns.

Please consider this response my supplementation of additional information pertaining to my complaint.

On February 16, 2010, I had an appointment with Dr. Harris regarding my ongoing hip and leg pain. The hip pain had become progressively worse over the past four years. I had previously expressed to Dr. Harris, at many, many prior appointments, my worry over this worsening hip pain. I have had two hip replacement surgeries, both at Vacca Valley Inter Community Hospital in Fairfield, CA, in the 1990's. Over the past approximately 4 years, I have developed an imbalance with walking; it as an instability in my step, causing me great worry that I may fall. As such, I have become very cautions about walking and this has greatly hindered my normal activities. The pain has been manifesting so long in my hip that my Left knee began hurting approximately two years ago. I have scheduled many appointments with Dr. Harris to discuss the knee and hip pain. He refused to refer me for any diagnostics, or to a specialist for other care. I asked for a referral to an orthopaedist. His answer was to prescribe me pain medication that I did not want and was afraid to take.

Last August, shortly after I learned of the DePuy hip recall, I again asked Dr. Harris to request copies of my hip replacement surgery reports so we could learn which hip implants I have. I asked again at my 02/16/2011 appointment with Dr. Harris. He reluctantly referred me for an X-ray. I thought I was being referred for hip X-rays, since the hips have been the most painful. He ordered a knee X-ray!

By February 25, 2011, I had not heard back from Dr. Harris's office regarding my request for the hip implant surgery reports. I called Vacca Valley Inter Community Hospital and spoke with the Records Department. They explained to me that they could not release the records to

me directly, that the request had to come from my doctor, and that the records must be released to my doctor. I was told that no request had come in. However, while I was on the phone with the records department, they told me that a fax request was just coming in from Dr. Harris. I was frustrated by yet another delay in getting this hip information.

Within the following week, I received the letter from Dr. Harris, firing me as his patient. I still awaited the copies of my hip replacement surgeries; there were no copies of medical records with the letter from Dr. Harris. I still had ongoing hip pain, still had instability with my step. I called his office and requested the records again.

I then self referred myself to Olympia Orthopaedics. I was treated by Dr. He sent me for X-rays during this first appointment. He then reviewed the X-rays with me at that same visit. He found that my hip implants were approximately 1 cm. off, causing one leg to be shorter than the other. Dr told me that this was most likely the cause of my knee pain and definitely the cause of my step instability and hip pain. So, after suffering for four years with hip pain, step instability, knee pain and a drastic decrease in my activity, all the while begging Dr. Harris to address this problem, i was diagnosed in one appointment. Dr. fitted me at this same first appointment with a lift in my shoe to balance the difference in my leg length. My hip pain is much improved, but not yet resolved because I lived with the height discrepancy for so many years. I have a follow up appointment with Dr. on 08/05/2011. My walking gait is also much improved.

While I was going through pre-operative testing in preparation for my 11/10/2010 open-heart surgery, Dr. asked me how long I had been taking endomiacin. I told him that Dr. Harris had prescribed it for me for several years. Dr. told me that endomiacin causes renal failure. I became very frightened because I had experienced renal failure after my second hip replacement surgery. I had discussed this at great length with Dr. Harris when I first became his patient, and provided this information in my medical history. Dr. Harris was aware of my history of renal failure yet prescribed a drug that causes renal failure. Had I known this risk, I would not have taken the endomiacin. Dr. instructed me to suspend taking endomiacin immediately. Instead of referring me for diagnostics for my hip pain, Dr. Harris continued to prescribe a pain medication that was very dangerous for me. He repeatedly ignored my

complaints about the pain and ignored my requests for help to diagnose and treat the pain.

On July 27, 2011, I called Dr. Harris's office to request copies of the hip replacement surgery reports which I had not yet received. I was told that they would be mailed to me. On 08/01/11, I received a copy of my Right hip surgery report only. There was no copy of my Left hip surgery, which is the hip that had been so painful, and the surgery implant which resulted in my renal failure. I called Dr. Harris's office to request a copy of the surgery report for the second hip. The receptionist told me to "Call your lawyer" and hung up on me. I was very distressed by this very rude and unprofessional conduct.

Please feel free to contact me if you need any clarification or further information. I look forward to your update.

Sincerely,

6 - Identity - Whistleblower and whistleblower's healthcare information - ...

Enclosures

OLYMPIA FAMILY & INTERNAL MEDICINE
3920 Capital Mall Dr. SW, Ste. #200 Olympia, WA 98502 Phone No. (360) 596-4899

AUTHORIZATION TO USE OR DISCLOSE MY HEALTH CARE INFORMATION

Patient Name: 4 - Healthcare information readily identifiable to a person - RCW 42.56.360(2) and RCW 70.02...

Previous Name: 4 - Healthcare information readily identifiab... Date of Birth: 4 - Healthcare information re...

I. My Authorization

You may use or disclose the following health care information. Check all that apply:

X All health care information in my record.

__Health care information in my medical record relating to the following treatment or condition:_____

__Health care information in my medical record relating to the date:_____

__Other (Immunization records, etc.) specify date(s):_____

You may use or disclose health care information re: testing, diagnosis, and treatment for: Check all:

__HIV(AIDS Virus)
__Psychiatric disorders/mental health
__Sexually transmitted diseases
__Drug and/or alcohol use

Information released from:
DR KIRK HARRIS
6881 LITTLEROCK RD SW
SUITE 101 TUMWATER 98512
360-943 3633

Information to be sent to:

Olympia Family & Internal Medicine
3920 Capital Mall Dr. SW, Ste. #200
Olympia, WA 98502

(21)

Reason for request:
X My request X Transferring Care __Attorney __Ins.Co. __Other:_____

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment.) However, I do have to sign an authorization form to take part in a research study or to receive health care when the purpose is to create health care information for a third party. I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Olympia Family Medicine. Based upon this authorization I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are: Fill out a revocation form. A form is available from Olympia Family Medicine. OR write a letter to Olympia Family Medicine. Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws no longer protect it.

4 - Healthcare information readily identifiable to a person - RCW 42.56.360(2) and R... 2/26/11 mailed 5.31.11 GO

Patient or legally authorized signature Date

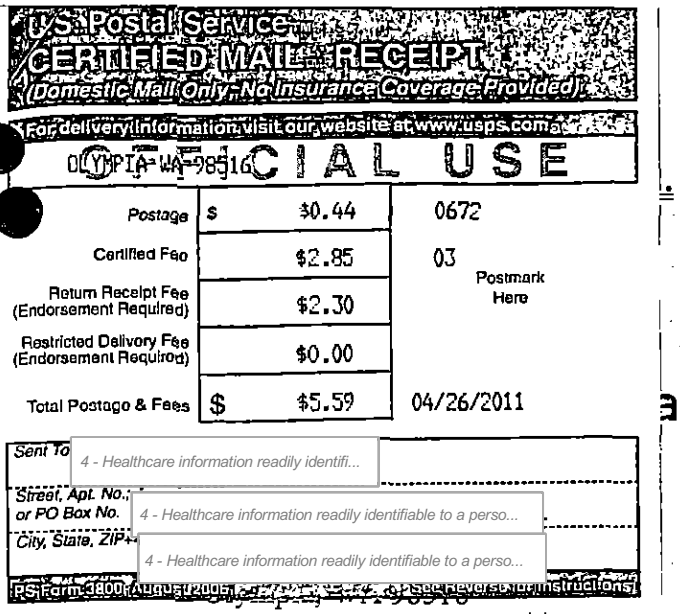
4 - Healthcare information readily identifiable to a person - RCW 42.56.360(2) and RC...

Printed name if signed on behalf of the patient Relationship (Parent, Guardian, etc.)

**THIS AUTHORIZATION EXRIRES IN 90 DAYS FROM THE DATE OF SIGNATURE.*

WITH

HD 2011-157968-000001


U.S. Postal Service
CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)
For delivery information, visit our website at www.usps.com
OLYMPIA WA 98516
OFFICIAL USE

Postage	$ $0.44	0672
Certified Fee	$2.85	03
Return Receipt Fee (Endorsement Required)	$2.30	Postmark Here
Restricted Delivery Fee (Endorsement Required)	$0.00	
Total Postage & Fees	$ $5.59	04/26/2011

Sent To 4 - Healthcare information readily identifi...
Street, Apt. No., or PO Box No. 4 - Healthcare information readily identifiable to a perso...
City, State, ZIP+4 4 - Healthcare information readily identifiable to a perso...
PS Form 3800, August 2006 See Reverse for Instructions

7010 0290 0000 2724 8E

Mailed 4.26.11
CA

6981 Littlerock RD SW Suite 101
Tumwater, WA 98512
360-943-3633 Tel
360-528-4643 Fax

are Letter

04/26/2011

Dear 4 - Healthcare informa...

I regret to inform you that as of today I will no longer be your primary physician. We feel that we are not able to meet your medical needs at this time. We will only attend to emergency needs for the next 30 days.

Please consult the local physician referral service, your county medical society, or the yellow pages of your telephone book as soon as possible so that you may find another physician who will assume responsibility for your care.

Sincerely,

Harris, MD

W. Kirk Harris, MD

Mailed 4.26.11
CA

W. Kirk Harris, M.D.
FAMILY MEDICINE

6981 Littlerock RD SW Suite 101
Tumwater, WA 98512
360-943-3633 Tel
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Termination of Care Letter

4 - Healthcare information readily i...

04/26/2011

Dear 4 - Healthcare inform...,

I regret to inform you that as of today I will no longer be your primary physician. We feel that we are not able to meet your medical needs at this time. We will only attend to emergency needs for the next 30 days.

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Sincerely,

Harris, MD

W. Kirk Harris, MD

4 - Healthcare inform...

4/25/11

She is verbally abusive to the staff, and does not make it clear what her agenda is. I listened to her talk about her sons, her grandsons, her daughter in law, and a whole host of off-topic subjects. We have many reasons to cut ties with this patient, and today was the last straw.

Please send her our generic discharge letter stating that we will no longer be her primary care office and that she can seek care elsewhere.

WH

4/22/11 Left message on patient's answering machine to return call.

4/25/11 at 1:51 pm patient returned my call. I was going over her x rays with her and she wanted to know "why the hell that Dr Harris only ordered knee films not hip films. I tried to explain and she became very upset "why doesn't he listen to me. "I told him that I couldn't even lay on it at times. "I feel like this is the same crap that happens to me with my heart" He didn't listen!! She was raising her voice to the point that I held the phone out from my ear! She asked about her records from her last Dr regarding her hip, did you get them I said no. again Tried

to explain that we had to fax a records request to them. "The hell you do I talked to them, they said that all you had to do was call and they would fax them right over. She gave the phone number to Nesha to call not fax!

Again I tried to explain. She was screaming at me "what's wrong with this office" I asked her to hold while I get Nesha. to Explain as well.

After Nesha was finished I picked up the phone to talk to 4 - Health... about sending her for a hip xray she replies "I get you, Nesha , Christy , and now he has you talked to me again.

Then she said to hell with it I will take care of this myself once and for all.

04/25/11 after Teresa tried to explain to 4 - Heal... . Teresa then put 4 - Heal... on hold thinking that I could explain better since I was the one who called the other office for there fax number. 4 - Heal... screamed at me. I explained to her that's how doctor's office work. They require a written authorization. She said no "I told you that you need to call them and get the records" I told her I did what I was told and she raised her voice and said "No you didn't." I really didn't know what to say. She just kept yelling at me. I said I was sorry for the inconviance Christy took over and said 4 - Heal... I am putting you on hold so that you could talk to Dr Harris.

Nesha

Telephone Action Log

4/22/4

Date	To/From	Subject
4/25/4 @ 1:51	Teresa / 4 - Healthcare inf...	Left mess on pt Answer machine IRC. pt R/C was giving Her. Her Results. Wanted to know Why the hell that Dr Harris ordered only Knee films Tryed to explain it & She became very upset. "Why doesn't He listen to me." "I told Him I couldn't even lay on my hip @ times I feel like this is the same crap that happened to me & my heart." (He D.Dnt Listen) She was Rasing her voice to the point that I held the phone out from me ear! ~~He~~ asked about her Records from he Last Dr RE (H/P) DiD We get them I said NO. & tryed to explain that We had to fax a Records Request to them. the hell you do I faxed to them they said that all ~~they~~ We had to do Was call. She gave the # TO Nesha to call not fax! again I tryed to explain. She Was Screaming

SEE REVERSE SIDE

me. "whats Wrong w this office. I asked
u to Hold while I get Nesha.

after Nesha was Done I picked up
the phone. to try & talk to ~~Got to~~ She Said to Hell with it
Im Gonna Take care of this once & for
all & Hung up on me.

Jenny

I Get you, Nesha, Christy & now he Has
you Talk to me again

SCOTTISH SOUTHERN CALIFORNIA

Problem List:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

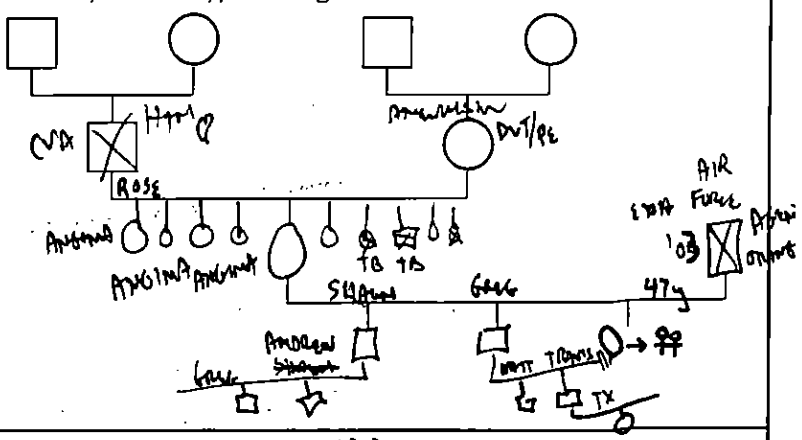
4 - Healthcare information readily identifiable to a person - RCW 42.56...

(call)

Hospitalizations/Surgeries:

1. L. THR Rep '02
2. R " " '04 (Revis Failure Epiphora)
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. TB 20yo (exc scars)

Family History/Genogram:



Testing/Results:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

Patient Education/Health Maintenance:

(Note on green sheet, right column)

Blood Pressure	(yearly)
Complete H&P	(yearly)
Pap/Pelvic (Culture)	(yearly, then q3y until 65yo)
Breast Exam/Mammogram	(yearly)
Eye and Teeth Exams	(yearly)
Chemistry Panel/Lipid Panel	(q5y)
Rectal/Guaiac	(yearly after 40yo)
Bone Density Scan	(50yo)
Colonoscopy	(q5y after 50yo)
TSH Screening	(60yo)

Prudent Diet/Overweight/Exercise
Daily ASA/Calcium
Birth Control
Depression
ETOH Abuse
Immunizations/Growth Chart (separate)
Flue Shot (yearly)/dT (q5-10y)/Varicella

Risk Assessment:

Metabolic Syndrome: Trig:_____ HTN:_____

Waist:_____ HDL:_____ FBS:_____

CAD/CVA/MI/PVD:	Smoker	50yo	Obese	DM
CHOL	FHx	Sedentary	Male	Previous HTN
Osteoporosis	Smoker	50yo	Thin	ETOH

Adult Health History Update

PROVIDERS SIGNATURE DATE

Patient's name: 4 - Healthcare information readily identifiable to a person - RCW...

Current medical problems:

BLOOD PRESSURE

CANCER

Previous Hospitalizations/Surgeries: (and year)

HIP REPLACEMENT 2002
HIP REPLACEMEN 2004

Family Medical History. Please indicate medical problems for each relative:

Mother DIED IN HER SLEEP. BLOOD PRES
Father BLOOD PRESSURE
Sisters 1 BIL ANEURISM (2) BLOOD CLOT
Brothers TB HEART
Sons /
Daughters /
FC?

Current Medications:

HYDROCHLOROT	25MG	QD
ATENOL	50 "	QD
ZOCOR	40 "	QD
LISINOPRIL	20 "	QD
FLUOXTINE	20 "	QD → 2 QD
DICLOFENAC	75 "	QD → BID

Any over-the-counter medications?

NO

Allergies:

NO

General:

Religion: CATHOLIC
Occupation:
Marital status: WIDOW
Years of schooling: 14
Date of last tetanus shot: 4 YRS AGO
Had a pneumonia shot?: NO

How are you feeling?
(circle answer)

During the past month, have you had:

1. frequent headache or vision changes? No Yes
2. dizziness or convulsions? No Yes
3. swollen glands or lumps? No Yes
4. difficulty hearing or ear pain? No Yes
5. dental problems or sore throat? No Yes
6. nose bleeds, allergies, sneezing? No Yes
7. shortness of breath or coughing? DOE No Yes
8. fevers, chills, or night sweats? No Yes
9. racing heart or chest tightness/pain? No Yes
10. swollen feet or ankles? No Yes
11. heartburn or indigestion? No Yes
12. nausea, vomiting, abdominal pain? No Yes
13. bloody or tarry bowel movements? No Yes
14. diarrhea or constipation? No Yes
15. painful or frequent urination? No Yes
16. skin problems or changes? No Yes
17. painful joints or muscles? No Yes
18. difficulty sleeping? No Yes
19. fatigue or low energy? No Yes
20. poor appetite for food or sex? No Yes
21. depression, anxiety, or irritability? No Yes
22. Do you use salt at the table? No Yes
23. Do you drink caffeinated drinks? No Yes
24. Have you ever used tobacco? No Yes
25. Do you drink alcohol? No Yes
26. Ever use recreational drugs? No Yes
27. What kinds of exercise do you do?

STRETCHING

28. Do you wear your seat belt always? Yes No
29. Are you sexually active now? Yes No
30. Are you satisfied with sex? Yes No
31. Any changes in your handwriting? No Yes
32. Have you ever considered suicide? No Yes
33. Do you have guns in the house? No Yes
34. Excessive thirstiness or hunger? No Yes
35. What form of birth control do you use? ___

For Men Only:

36. penile discharge or drip? No Yes
37. lumps or swelling on your testes? No Yes
38. erection difficulty or poor stream? No Yes

For Women Only:

39. Date of last menstrual period: ___
40. Any change to your periods? No Yes
41. Any spotting between periods? No Yes
42. Do you do a monthly breast exam? Yes No
43. Any vaginal itching or discharge? No Yes
44. Ever had an abnormal Pap smear? No Yes
45. When was your last Pap smear? ___

HANDOUT 3462

Risk:	High	Med.	Low
CAD			
Cancer			
Diabetes			

Allergies

4 - Healthcare information readily identifia...

Medication	Visit Dates												
	10/29/10	1/4/11	1/20 11	1/24 11	3/9/11	2/28/11	3/9/11	3-1 11	3-16 11	3-23 11	4-10 11	4-20 11	
Prozac 40mg	30 im												
ASA 81mg QD							PODIE TRUST	~~GO~~ RFX2					
K-Dur 10meq 1 po QD (Lasix)		90 x1y						60 RFX2					
Dalmane 15mg 1 qhs			30 x1										
Allopurinol 100mg 2 qd-bid				60 x1		120/2	TIO	✓	Q10	✓	✓		
Tylenol 500mg 4 times a day													
K-Dur 10meq 1 po Bid					60/1								
Lotrisone cream bid 15gm						15gm x1							
Colchicine 0.6mg BID							x1w						
Furosemide 40mg							30 2						
metoprolol 25mg							60 2						
Colcrys 0.6mg 1 po bid								~~GO~~ RFX1	~~GO~~ RFX1		60 1		
metformin 500mg 1 po bid										60 1y			
Vicodin											MD Req		
Percocet												40 NR	

Allergies

Codeine

4 - Healthcare information readily identifiable t...

Visit Dates

Medication	8-27 08	10-7 08	10-23 08	2-9 09	9-8 09	10-8 09	11-12 09	12-9 09		2/11 10	5-27 10	6-3 10	
ColChicine 0.6mg tgh	12 NR												
Fluoxetine ~~20mg~~ 40mg 1 QD		30 3	✓	.30 1Y		.90 x1y	✓	✓	✓	✓	✓	✓	✓ D
Lanoxin 0.25mg 1 QD		30 3	✓	.30 1Y	30 x3	.90 x1y		✓	✓	✓	✓	✓	✓
INDOCIN 25mg TID			.90 .1yr	✓		.90 x1y		.90 prn	✓	✓	✓	✓	✓
ATENOLOL 50mg QD			.30 1yr	✓		.30 x1y		✓	✓	✓	✓	✓	✓
SIMVASTATIN 40mg QD			.30 1yr	✓		.30 x1y		✓	✓	✓	✓	✓	✓
HCTZ 25mg QD			.30 1yr	✓		.30 x1y		✓	✓	✓	✓	✓	✓
ZESTRIL 20mg QD			.30 1yr	✓		.30 x1y		✓	✓	✓	✓	✓	✓
PROSOM 2mg BID						.30 x1y		✓	✓	✓	✓		
SOMA 350 mg							50 x1	INEFFECTIVE					
ROBAXIN 750mg lpo bid-tid										60 RFx1			
Wellbutrin SR 150mg BID											60 x2		
Augmentin 500mg BID											20 NRF		
Dalmane 15mg QHS							SLEEPS VERY WELL!				30 x2	✓	✓
Metformin 500mg BID												60 x1	✓
	8.3 10	9-22 10	10.4 10										
metformin 500mg BID	60 6												
Bactrim DS 1po bid		20 0											
ATIVAN 0.5mg BID prn ANX			30 2										
START LIXIANA 10mg 1poqd			30 1										

Risk:	High	Med.	Low
CAD			
Cancer			
Diabetes			

Allergies

CODEINE

4 - Healthcare information readily identifia...

Medication	Visit Dates: 10/10 07	10/22 07	11-19 07	11-19 07	3-19 08	3/27 08	3-31 09	4-23 08	4-30 08	4-29 08	6/18 08
Prozac 20mg 1qd	30 6	✓				30 X6					✓
Hctz 25mg 1qd	30 6					30 X6					✓
Atenolol 50mg 1qd	30 6			30 X6		30 X6					✓
Zocor 40mg 1qd	30 6					30 X6					✓
Lisinopril 20mg 1qd	30 6			30 X6				30 6			✓
Digoxin 0.25mg 1qd	30 6					30 X6					✓
Diclofenac 75mg 1 b.i.d	60 6	↓ ONLY ONE!				60 X6					X
Indomethacin 25mg TID								90 6			✓
Ambien CR 6.25mg QHS	INTERFERE	30 X2	DOPED NEXT DAY			30 X6					
Simvastatin 40mg Bid			30 X1								
AMBIEN 10mg						30 X6	HALLUCINATES				
XANAX 0.5mg QHS prn						30 X2	off				
Lancets						100 X14					
Test Strips						100 X14					
Bactrim DS						14 NR	D/C				
Macrobid Bid UTI							7/14 NR		X	20 NR	
Allopurinol 100mg QD								30 6		X	
Valium 10mg QHS								30 6			✓ OFF 2° FATIGUE + SEDATION
Metformin 500mg									60 X2	60 9	✓
NAPROSYN		HELPS	HIP	PAIN!							✓
MIDRIN (DUPHALGRAN) QHS prn HA's.											✓
PRILOSEC											

Risk:	High	Med.	Low
CAD			
Cancer			
Diabetes			

Allergies

COZAAR

4 - Healthcare information readily ide...

Medication	Visit Dates: 6-25-06	7-27-06	8-24-06	10-11-06	11-6-06	1/15/07	1/30/07	2/13/07	3.22.07	4-3-07	5.10.07	5/21/07
Hctz 25mg 1 qd	30 / 1	✓	30 / 3		30 / 6	✓	✓				30 / x6m	
Atenolol 50mg 1 qd	60 / 1	✓	30 / 3		30 / 6	✓	✓				30 / x6m	
SIMVASTATIN Zocor 40mg 1 qd	30 / 1	✓	30 / 3		30 / 6	✓	✓				30 / x6m	
Lisinopril 20mg 1 qd	30 / 1	✓	30 / 3		30 / 6	✓	✓				30 / x6m	
Prozac 20mg 2 qhs	60 / 1	Δ (INEFFECTIVE)										
Diclofenac 75mg 1 bid	60 / 1	✓	60 / 1		60 / 6	✓	✓				60 / x6m	
VALIUM 10mg QHS	30 / 2	30 / 1 vivid dreams	30 / 5	Δ								
Oxapro 10mg ½ - 1 qd	30 / 2	30 / excessive sedation		30 / 6	OFF							
~~Diazepam 5mg~~ AMBIEN CR 12.5mg				30 / 2								
Augmentin 500mg 1 bid				20 / NR								
VALIUM 5mg BID prn					30 / 1	✓		30 / x6m	✓	✓	STOP Anxious	
Digoxin 0.25mg 1 qd					30 / 1		30 / 1yr		✓	✓	30 / 6	
Indocin 25mg 1 tid						50 / 2	off (GASTRITIS)					
ANTACID DAILY												
Prilosec 20mg									30 / x2			prn
Allopurinol 100mg 1 qd									30 / x2			
[illegible]										15gm / x2		
MYLANTA 1 qid HA										40 / x2	✓	prn

W. KIRK HARRIS, M.D.
6981 Littlerock Rd. S.W., Suite 101
Tumwater, WA 98512
Ph. 360-943-3633
Fax 360-528-4643

Administered by:	R. Gin MA
Date Administered:	1/5/11
Route: Check IM or Intranasal after administering vaccinations.	
IM ( ) R (L) Deltoid Vaccine: Influenza Virus Vaccine Dose: 0.50 ml	
~~Intranasal~~ _____ ~~Vaccine: Intranasal LAIV~~ ~~Dose: 0.2 ml (0.1 ml in each nostril)~~	
Lot #: 11169015B Expiration Date: 05/2011	

2010-2011 Corporate Vaccination Consent & Release

1. Decide if you would like the 'flu shot' or the Intranasal Flu Mist and circle your choice below – review the Vaccine Information Sheets for details on both vaccines
2. Answer the questions below
3. Take this consent form to the nurse and review your answers

Name: 4 - Healthcare information readily identifi...

Date of Birth: 4 - Healthcare information r... Age: 74 Sex: M ____ F X

VACCINE PREFERENCE (circle one)

FLU SHOT **INTRANASAL FLU MIST**
(not eligible for people over 50 years of age)

CONSENT:
I hereby acknowledge that I have received and read the information sheet corresponding to my vaccination choice: "Inactivated Influenza Vaccine – What You Need To Know 2010-2011" **(VIS date: 08/10/10)** for the inactivated flu vaccination shot or "Live Intranasal Influenza Vaccine – What You Need to Know 2010-2011 **(VIS date: 08/10/2010)**. I wish to receive, and I have had an opportunity to ask questions.

Please check Yes or No for the following questions	**Yes**	**No**
1. Do you have a severe egg allergy?		
2. Are you allergic to the preservative Thimerosol?		
3. Have you ever had a severe adverse reaction to a flu vaccine –either the shot or the intranasal mist?		
4. Are you sick today?		
5. Have you ever had Guillain-Barre Syndrome?		
6. Do you have thrombocytopenia or any blood disorder that would prohibit a shot in your muscle?		
7. Women: Are you pregnant or could you become pregnant in the next month?		
If requesting Flu Mist – please also answer the following questions		
1. Are you 50 years of age or older?		
2. Do you have a long term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia, or other blood disorders?		
3. Do you have a weakened immune system because of disease that affects the immune system, long-term treatment with drugs such as steroids, or cancer treatment with x-rays or drugs?		
4. Have you received any other vaccinations in the past 4 weeks?		

*** "Yes" answers may disqualify you from receiving the flu shot or the intranasal mist.**

I understand the risks of receiving the influenza vaccine, and I acknowledge that I have freely chosen to assume such risks by signing this release and receiving this vaccine. Furthermore, I hereby release and forever discharge, for myself, my heirs, executors, administrators, and assignees, my employer, its subsidiaries and their directors, officers, employees, agents, representatives, successors and assigns, as well as the independent professional physicians and nursing staff retained by my employer in connection with the administration of the flu vaccine, from any and all claims, demands, actions, and causes of action which may result or arise from my receipt of this vaccine.

Signature: _____ Date: _____

forgot to have pt fill out paperwork R. Gin MA

NORTHWEST HEALTH & OSTEOSCREENING™
Mobile Health Screenings
P.O. Box 44413 • Boise, ID 83711 • (208)378.4584
www.nwosteo.com

INFLUENZA VACCINE (FLU SHOT) CONSENT FORM

1. **Have you ever had an allergic reaction to flu vaccine?** Yes or (No)
2. **Are you allergic to eggs, or egg products?** Yes or (No)
3. **Do you have a history of Guillain-Barre Syndrome? (illness associated with the swine flu in 1976 characterized by fever, nerve damage, and muscle weakness)** Yes or (No)
4. **Are you allergic to thimerosal (a mercury-based preservative)?** Yes or (No)
5. **Are you allergic to latex?** Yes or (No)
6. **Do you feel ill today or do you have a fever?** Yes or (No)
7. **If you are female, are you pregnant? # Weeks_____** Yes or (No)

Heard about the clinic from: Newspaper / (Physician) / Hospital / Street Sign / Employer / E-mail
(Circle ones that apply) Store Advertisement / Friend or Relative / Other _____

I hereby certify that the foregoing history is true and complete to the best of my knowledge and I have received and read the "Vaccine Information Statement" from the CDC, have had an opportunity to ask questions that were answered to my satisfaction, and do wish to receive the flu vaccination fully understanding the risks and the benefits. I hereby consent to the administration of the flu vaccine (flu shot). Furthermore, I hereby release and forever discharge for myself, my heirs, executors, administrators and assignees, NW Health and OsteoScreening and their employees, owners and representatives, as well as the company sponsoring this event and their agents, representatives, employees, successors, assignees, governing bodies, and advisory committees from any and all claims, demands, actions and causes of action, which may result from participation in this program.
Your personal information and results shall be held strictly confidential. I understand Northwest Health and OsteoScreening is not a Medicare participating provider. Insurance/Medicare will not be billed; however, forms/receipts are available for reimbursement.

PARTICIPANT INFORMATION AND CONSENT

LAST NAME: FIRST NAME: MI:
ADDRESS: CITY: STATE: ZIP:
PHONE: E-MAIL:
BIRTHDATE: AGE: 72
SIGNATURE: DATE: 10/23/08

4 - Healthcare information readily identifiable to a person - RCW 42.56.360(2) and RCW 70.02.020

FOR CLINIC USE ONLY

MANUFACTURER AND LOT#: SANOFI-FLUZONE LOT #: NOVARTIS—FLUVIRIN LOT: X7X820A
EXPIRATION DATE: 05/2009
SITE OF INJECTION: R / L DELTOID
SIGNATURE AND TITLE OF VACCINE ADMINISTRATOR:
PAYMENT
Cash $ Check $ Credit Card $ FLUGRAM Co. Sponsored

VACCINE RECORD & CONSENT FORM

I have read the information sheet about Flu **VACCINE**. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and request that this vaccine be given to me or to the person named below for whom I am authorized to make this request.

INFORMATION ON THE PERSON TO RECEIVE VACCINE

CLINIC USE ONLY

4 - Healthcare information readily identifiable to a person - RCW 42.56.360(2) and RCW 70.02.020 71

NAME (Please Print) Birth date Age

Dr. W. KIRK HARRIS M.D.
Clinic Identification

4 - Healthcare information readily identifiable to a person - RCW 42.56.360(2) and RCW 70.02.020 10/10/07

Address City Date Vaccinated

VACCINE RECORD & CONSENT FORM

I have read the information sheet about _____ **VACCINE**. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and request that this vaccine be given to me or to the person named below for whom I am authorized to make this request.

INFORMATION ON THE PERSON TO RECEIVE VACCINE

CLINIC USE ONLY

VACCINE RECORD & CONSENT FORM

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ATION ON THE PERSON TO RECEIVE VACCINE

CLINIC USE ONLY

4 - Healthcare information readily identifiable to a person - RCW 42.56.360(2) and RCW 70.02.020 70

Name (Please Print) Birth date Age

Dr. W. KIRK HARRIS M.D.
Clinic Identification

4 - Healthcare information readily identifiable to a person - RCW 42.56.360(2) and RCW 70.02.020 11-16-06

Address City Date Vaccinated

4 - Healthcare information readily identifiable to a person - RCW 42.56.360(2) and RCW 70.02.020 Chiron 71827

State Zip Phone # Manufacturer & Lot #

4 - Healthcare information readily identifiable to a person - RCW 70.... LA RA

Signature of person to receive vaccine or authorized perso Site of Injection (IM)

Signature of Nurse

DATE	AGE	TEMP	RESP	PULSE	BP	WT	PAIN	TOB	CHIEF COMPLAINT	COUNSEL
11/12/09	73		18	57	140/62	NO		Θ	MVA	Pox 97%
12-7 CM									R/S	
12-10 09	73		22	62	139/72	NO		€	R MK PM INTO R SH. paperwork PT + MASSAGE TIW	
3/9/10	71		20	63	144/82	NO		Θ	MK PM ↓↓ INTO ARMS. ↓↓ (B) SH. ROM: post accident ✓ R MK 45°, L MK 25°	97 pox
5:27 10	74		20	58	130/87	NO		Θ	L. CP ↑ SLEEP AM DRY, ↓ NAG, ↓ APP, LWI 112-121 ↓/↓ BP R. EAR DEAFENING HR's	Pox 96
6/3/10			16	66	146/80	200		€	Go over Labs	Pox 96%
6-1 10	74		18	70	128/78	NO		Θ	UNSTEADY ON FEET. L. SH DISCOMFORT. DOE CONSISTENT go over labs 93-154	pox 97
9/9/10	74		20	57	100/52	NO	190	Θ/	DEPRESSED RE: SONS. CRIES DAILY. (CS) DIZZY RBS: 137	→LIFE-LINE!
9/21/10	74		18	85	135/82	190	BS 2pm: 137	€	SLOWLY CRAWLS OUT OF BED. DEPR! ↓APP. BP follow BP LOW, LETHARGIC, HASN'T FELT GOOD FOR 1 YEAR	Pox 96% 75-165
10/4/10	74	CR	20	95	139/78	195	GRANDSON MVA.	€	CHEST TIGHT > 2d / SOB / DOE / TIRED BP f/u SHAKINESS, NO MEDICATION! 126-161/54-82 morning BS 95	pox 98
1/5/11	74		18	69	148/82	188.5			F/u Open heart surgery N/C. BS: 182 pox: 96	FLU SHOT ✓
1/20/11	74		18	69	130/68	190		Θ	(R) foot ankle swollen, pain. Pox 98%	
2/6/11	75		20	72	122/62	202		€	HURTS TO WALK! fatigue. Pox 98% Gout (R) foot - pain across back.	
3/16/11	75		20	68	140/90	199.5		Θ	INSOMNIA POSTURE BETTER ON COLCHICINE/ANOPURINOL med V for Gout	pox 96
4/20/11	75		16	76	136/84	200		€	WORSENING ↓ EW. NOTR Knee into thigh pain	

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04/20/11

4 - Healthcare in...

75yo

03/11 CMP WNL. WBC 8, HCT 43, PLT 247.
Patient is not having gout on increased dose Allopurinol 300mg qd.
She has had worsening left knee pain for the past three weeks. This is well localized into the joint but radiates up into the thigh such that she is limping with ambulation. Pt denies any trauma, injuries, or accidents.
Exam: 136/84
Knee exam: No bruising, discoloration, or deformity. Nontender/full ROM. Ligament testing shows no significant/abnormal laxity. No joint line nor patella manipulation tenderness. There is some generalize swelling to the left knee. No DVT is palpated in the inner thigh. Negative Homan's sign. She does not have pretibial edema.

Impression:	DJD Left Knee 715.16	C-spine DDD 722.4
	Type 2 Diabetes 250.00	Hypertension 401.1

Plan: Start Percocet 5mg/325mg tid prn severe knee pain. we will send her for knee films to evaluate extent of DJD. Precautions given for calling/returning w/ positive feedback.

jrp

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03/16/11

4 - Healthcare inf...

75yo

02/11 CMP WNL except Potassium 3.0 and Creatinine 1.3. Patient was increased to Potassium 10meq bid with instructions to recheck blood work in one month.

Swelling is well controlled on Lasix 40mg qam. Blood pressures is fairly well controlled with Metoprolol 20mg bid.

Patient saw podiatrist Dr. Stone on 03/09/11 for significant pain from gout. At that time she had some improvement on increased dose Allopurinol 200mg qd. We spoke on the phone and agreed to increase further to 300mg qd and to add Colchicine 0.6mg qd-bid.

The patient is happy to report that her gout pain is significantly improved on increased dose gout medication.

She is still bothered by some insomnia and secondary fatigue saying that she simply has not recovered from her open heart surgery in January. She does not have the drive to walk for exercise yet. She still feels like her left leg is a bit unsteady. The patient c/o no cold, cough, fever, chills, or sore throat. There have been no interruptions to sleeping, eating nor activity patterns. Pt c/o no itchy, runny, eyes & nose w/ sneezing. Pt denies any chest pain, shortness of breath, palpitations, racing heart, and skipped beats. Complete Review of Systems otherwise minimized.

Exam: 140/90 199# Room Air Pulse Ox 96%

Cardiopulmonary exam benign. No LE edema. Right foot shows continued third toe tophus and great toe mild redness and swelling without significant pain or heat.

Impression:	Right Foot Gout 274.9	Insomnia 780.52
	Type 2 Diabetes 250.00	C-spine DDD 722.4
	CHOL 272.0	Hypertension 401.1
	DJD Knee 715.16	Gastritis 535.50

Plan: Increase Allopurinol to 300mg qd and continue Colchicine 0.6mg bid. Continue other meds unchanged.

Recheck CBC and CMP to further evaluated Potassium level on increased dose and the possibility of anemia contributing to ongoing fatigue/left leg unsteadiness. Precautions given for calling/retuning w/ positive feedback. Further evaluation / treatment as indicated. RTC prn.

jrp



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2/28/2011

4 - Healthcare inf...

75yo

Pt started Allopurinol 100mg bid but has not had much improvement in her foot pain. This discomfort radiates from ankle through mid-foot to distal foot including the toes. Pt denies any trauma, injuries, or accidents.
Pt complains of ringworm rash under the breasts and would like something stronger than OTC cream.
Pt is upset because she feels that her sons are unappreciative in that they forgot her birthday. She discusses, at length, the troubles that she has had with her boys through the years.
She is tired but only describes some discomfort across the back. Pt denies any chest pain, shortness of breath, palpitations, racing heart, and skipped beats.
Exam: 122/62
Foot exam is completely unremarkable with no redness, heat, pain nor swelling elicited/detected. She has strong pulses in the feet. Cardiopulmonary exam benign. No LE edema. She had a blowing early systolic murmur.

Impression:		
	Right foot Gout 274.9	Insomnia 780.52
	Tension headaches 307.81	Type II diabetes 250.00
	Left shoulder DJD 715.11	C-spine DDD 722.4
	CHOL 272.0	Hypertension 401.1
	DJD knee 715.16	Gastritis 535.50
	Anxiety 300.00	Depression 311
	Breast tinea 110.9	Adjustment reaction 309.9

Plan: Double Allopurinol to 200mg bid for gout.
Start Lotrisone cream to breast tinea bid prn.
Will check CMP on current medicines.
Will refer pt to podiatrist for further evaluation of her persistent foot pain.
Prescriptions were sent to diabetes supply companies for test strips both on 1/13/2011 and 2/18/2011.
Precautions given for calling/returning w/ positive feedback. Pt will be seeing cardiologist, Dr. Brennan, in 2d for interval assessment. Further evaluation / treatment as indicated. RTC prn.

LKM



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915-7733

01/26/11

4 - Healthcare inf...

74yo

01/11 CMP WNL except Potassium 3.3. Glucose was 130. WBC 8, HCT 40, PLT 244. Patient was called and told that she was low on Potassium in 12/10 and was supplemented in the hospital. She has to continue on Lasix for leg swelling but is currently not taking a Potassium supplement pill along with it. She was given a Rx for Potassium 10meq qd to be taken as long as she is on the Lasix daily.

She is taking Dalmane 15mg qhs for insomnia but complains that it has a slow onset. She has been on other sleep meds and wishes to continue on this one.

For the past ten days that patient has had right foot swelling and discomfort. This is limited to the ankle and foot. Pt denies any trauma, injuries, or accidents. She has a constant, right, third, distal toe tophus but is not currently adhering to a strict low-purine diet nor is she on gout preventive medication. She may not take Indocin because of the renal and cardiac side effects.

Patient is now two months status post aortic valve replacement surgery for aortic stenosis and reports that she has no chest pain and no SOB/DOE. She is attending cardiac rehab classes and is building up her exertional tolerance nicely. She has followed up with the cardiologist and has received a good report.

Pt c/o two-sided, mildly-moderately severe, constant headaches which radiate into the neck and have no associated vision changes and vomiting. These are intermittent and have not responded recently to OTC meds.

Exam: 130/68

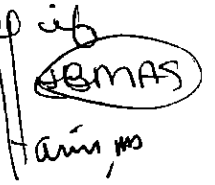
Cardiopulmonary exam benign. She has trace LE pitting edema with the right foot generally being somewhat larger than the left. Negative Homan's sign. No DVT palpated in either calf There is indeed a tophus which is bright red and the shape of an M&M on the upper tip of her right third distal toe. She has a well-healed, chest-wall sternotomy scar. No signs of infection (redness, heat, pain, swelling, drainage). Palpation recreates some general aching chest discomfort on both mid-clavicular lines.

Impression:	Right Foot Gout 274.9	Insomnia 780.52
	Tension Headaches 307.81	Type 2 Diabetes 250.00
	Left Shoulder DJD 715.11	C-spine DDD 722.4
	CHOL 272.0	Hypertension 401.1
	DJD Knee 715.16	Gastritis 535.50
	Anxiety 300.00	Depression 311

Plan: Start Allopurinol 100mg qd-bid for gout. This does not appear to be an acute attack so we will simply ease into anti-gout treatment with conservative Allopurinol. We will avoid Colchicine or NSAIDs now. Suggested Tylenol 500mg qid for pain.

At last check in 09/10 her AIC 5.7. We will plan on recheck in 03/11 along with Potassium redraw on supplementation. Precautions given for calling/returning w/ positive feedback. Further evaluation / treatment as indicated. RTC prn.

jrp 1/28/11 haven't gotten meds yet. will call if there are any concerns



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01/05/11

4 - Healthcare inf...

74yo

09/10 CMP WNL except Glucose 121. A1C 5.7. WBC 9, HCT 45, PLT 178. UA showed large leukocyte esterase and 4+ WBCs. TSH WNL. She was called and encouraged to continue antibiotics.

Patient saw cardiologist, Dr. Brennan, on 10/29/10 regarding chest presstue and tighmess with SOB. He gave her nitroglycerin and suggested angiogram to evaluate for MI. BMP WNL except glucose 133 and Creatinine 1.5. Chest X-ray showed scaring from prior granulomatous change. Nuclear Stress Test was unremarkable.

11/02/10 the patient was admitted to Providence Hospital regarding consultation regarding progressive chest pressure, fatigue and DOE. Chest X-ray showed granuloma and pleural fibrosis with no acute cardiopulmonary process.

Echocardiogram showed a stenotic aortic valve with less than 1cm squared aortic valve area. WBC 13, HCT 32, PLT 83. CMP WNL. Glucose range 122-186. Patient underwent aortic valve replacement surgery through an upper-mini sternotomy incision and recovered nicely. Post operative chest X-ray was WNL. She was discharged from Providence Hospital on 11/13/10 and followed up with cardiothoracic surgeon, Dr. Quinton, on 11/15/10. She was doing well at that time after her post opt atrial fibrillation converted to normal sinus rhythm with medical therapy. EKG confirmed NSR.

The patient then had the month of December with Providence South Home Health checking her wound and assisting with her mobility and recovery.

Patient is doing well on aspirin 325mg qd, Vicodin 5mg qhs prn, Metoprolol 25mg bid, Simvastatin 20mg qd, Lasix 40mg qam, Prozac 40mg qd, Metformin 500mg bid and Lorazepam prn. Her Amiodarone and Potassium were discontinued a month ago. She has plans to follow up with the cardiologist in one to two months.

Patient is happy to report that she feels very energetic, has not SOB, there is no DOE, fatigue or depression, and she is ready to dance again. She is very pleased with the outcome of her surgery but still has some mixed feelings about the delay in the diagnosis regarding her aortic stenosis. She is eating well, sleeping well, voiding and stooling normally with minimal pain. She knows that if she does not take Lasix she will get leg swelling.

Exam: 18 69 148/82 188#

Cardiopulmonary exam benign. No LE edema. She has a well-healed, upper-sternotomy scar. No signs of infection (redness, heat, pain, swelling, drainage). Pulses are strong with no lower extremity edema.

Impression:

Status Post Aortic Valve Replacement Surgery for Aortic Stenosis	
Type 2 Diabetes 250.00	Left Shoulder DJD 715.11
C-Spine DDD 722.4	CHOL 272.0
Hypertension 401.1	Gout 274.9
DJD Knee 715.16	Gastritis 535.50
Anxiety 300.00	Insomnia 780.52
Depression 311	

Plan: Continue current medicines unchanged. Refilled Simvastatin and Lasix and sent her for interval CMP and CBC.

Strongly encouraged her to begin a cardiac rehab program now that she has fully recovered with her surgery. She will follow up with cardiologist, Dr. Brennan, on 03/22/11.

Consent form signed and flu shot administered with no reaction. Precautions given for calling/returning w/ positive feedback. Further evaluation / treatment as indicated. RTC prn.

1/11/11 flu case Pt feeling very well today still Dancing
jrp asking for a talking BS machine. Gave Pt # for free Talking Diabetic meter Voice point

Harris, MD

11/09/10 4 - Healthca... /Teresa

Follow up call. I (Teresa) called 4 - Healt... to see how her appt with Dr. Brennan went. She became very angry and states that she & her sons are upset. She feels like these signs/symptoms have been going on too long. After talking with Dr Brennan, Joyce states that he even feels the same way. I suggested that she talks to Dr. Harris about her feelings and she refuses and states "that he is lucky that her son Greg has not showed up in person to talk about this with him. Both of my sons are very angry with him as well." She will be having open heart surgery tomorrow on 11/10/10 @ 5:30am to replace a valve. Depending on the outcome Dr. Harris will be receiving a letter from her lawyer and also "how dare Lynn call her about a bill that her insurance didn't pay. I (4 - Hea...) told Lynn wait until you see my hospital bill you will be getting. This is all Dr. Harris' fault." 4 - Healt... asked me to relay this information to Dr. Harris. 4 - Hea... then asked why we told her that her EKG was normal when cardiologist's test was abnormal. I (Teresa) explained the difference between an EKG and a nuclear cardiolyte study. How our test is a resting test and the cardiolyte is a stress test with medication injection, which stresses the heart. After the explanation of the difference between the tests, she seemed to calm down. I (Teresa) again asked if she would like to talk to Dr. Harris, so she could go over these feelings. Again, she declined. She gave me her son Greg's phone number, incase I wanted to check on her @ Mother Joseph's.

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10/04/10

4 - Healthcare inf...

74yo

09/10 CMP WNL. WBC 9, HCT 45, PLT 178. A1C 5.7. TSH WNL. Urine analysis showed a large amount of WBCs and she was treated with Bactrim DS bid x 10d for UTI. She is not complaining of any bladder symptoms today.

Patient is now off Atenolol and Lisinopril and her BP ranges 126-161/54-82 on HCTZ 25mg qd and Digoxin 0.25mg qd. Patient reports that her grandson was in a serious car accident and she has been under quite a bit of stress. For the past two days she has had well-localized, sternal chest tightness with associated SOB, fatigue and DOE.

She has been taking increased dose Prozac for one to two years and still feels very depressed and feels like she has no ambition whatsoever.

Patient reports that she has been feeling quite anxious and even panicky. She is dealing with quite a bit of family stress with her uncooperative, unsupportive sons and is seriously considering moving back to Scotland to simply get away from the whole situation. She also realizes, however, that it is an unreasonable idea and that she will probably be stuck here in a less desirable personal situation.

Otherwise she is doing well on Indocin for arthritis, Prilosec for heartburn, and Metformin with good blood sugar control.

Exam: 98.2° 20 95 139/78 195# Nonsmoker

WNWD elderly WF in NAD; pleasant, cooperative, talkative. EOMI, PERRL, TMs clear, pharynx benign. Teeth in adequate repair. No cervical nodes nor JVD. Heart RR w/o M. Lungs CTAT. Abd soft, flat, NT to palp w/o HSM nor masses; BS+. Extr FROM w/ strong, symmetrical pulses in the lower extremities; no CCE. Office EKG shows NSR 72.

Impression:

Chest Pain 786.50	Type 2 Diabetes 250.00
Left Shoulder DJD 715.11	Fatigue 780.79
PAF 427.81	C-spine DDD 722.4
CHOL 272.0	Hypertension 401.1
Gout 274.9	DJD Knee 715.16
Gastritis 535.50	Anxiety 300.00
Insomnia 780.52	Depression 311
UTI Resolved 595.0	

Plan: DC Prozac (ineffective). Wait five days and then start Lexapro 10mg qd for improved depression control. Other supportive measures described Ativan 0.5mg qhs-bid prn anxiety/panic at length with positive feedback.

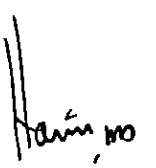
Reassured the patient about the benign nature of her office EKG however, because of persistent symptoms, we will send her for a nuclear cardio light study. Room Air Pulse Ox is a reassuring 94%. Precautions given for calling/returning w/ positive feedback. Further evaluation / treatment as indicated. RTC prn.

Nature of the presenting problem: Moderate severity if not treated.

Counseling/Coordination of care: Discussion regarding impressions, prognosis, risk/benefits, treatment options, follow-up, patient education: 15-25minutes.

Medical Decision-Making: Multiple diagnoses w/ extensive amount of data to be reviewed, moderate complexity of decision making and moderate morbidity.

jrp



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9/21/2010

4 - Healthcare info...

74yo

Pt is complaining that she is lethargic, has not felt good for a year, is suffering with low BP, has a poor appetite and worsening depression. She says that her sons are no longer supportive of her and that she is more depressed than ever. If she sits up in bed and becomes dizzy, she lies back down. Some mornings it may take her an hour to slowly crawl out of bed. She is afraid that she is going to fall, because if she does, she is so weak she is unable to get herself up off the floor unless she can crawl to her stairs and get her rump up onto the first or second step in order to stand up again.
She's taking Metformin 500mg bid with blood sugar range 75-165. She feels lethargic and as if all of the vitality has been taken out of her.
Exam: 135/82 Room air pulse ox 96%
Cardiopuhnonary exam benign. No LE edema.

Impression:		
	Hypertension 401.1	Type II diabetes 250.00
	Left shoulder OA 715.11	Fatigue 780.79
	PAF 427.31	C-spine DDD 722.4
	CHOL 272.0	C-spine strain 847.0
	Hypertension 401.1	Gout 274.9
	DJD knee 715.16	Gastritis 535.50
	Anxiety 300.00	Insomnia 780.52
	Depression 311	Adjustment reaction 309.9

Plan: Last month, we stopped Atenolol. This month we will stop Lisinopril. She will continue only on HCTZ for BP control and Digoxin 0.25mg qd for CHF management. RTC 1mo for interval assessment and BP diary review.
Because pt is so weak, we gave her a Lifeline application to complete.
Basic metabolic panel, CMP, CBC, TSH, UA and A1C. Will call patient w/ results when received. Precautions given for calling/returning w/ positive feedback. Further evaluation / treatment as indicated. RTC prn.

LKM

Harris, MD

Urgent Care South

6981 Littlerock Rd SW, Tumwater WA 98512 '10 SEP 9 PM 5:11
Phone 360-943-3633 Fax 360-528-4643

NPI 158 866 2068 Date: _____

PATIENT INFORMATION

Name	Insurance	Soc Sec Num
4 - Healthcare information readily identifiable to a person - RC...	MED TRICA.	4 - Healthcare information readily identifiable to a pers...

Usual Medical Provider	Reason for Visit	Age	Birthdate	Patient Telephone
360-915-7233 MED ATRICA	DIZZINESS	74	4 - Healthcare information readily identifiable to a person - RC...	

ALLERGIES	MEDICATIONS	LAST TETANUS
NO	LOTS.	6 YES

CONSENT FOR TREATMENT AND RELEASE OF INFORMATION

I hereby consent to all surgical and medical treatment as ordered by the medical care provider or consultant who may assist him/her. I authorize Urgent Care south to release to my insurance company / Medicare the medical and surgical information required to settle my insurance/Medicare claim, and authorize assignment of insurance/Medicare benefits.

Parent or Guardian_____ Patient_____ Date_____

MEDICAL PROVIDER SECTION

T	R	P	BP	Wt	LMP	CC:
	20	57	159/52	NO		x 3 days DIZZY. LKM-HARRIS

79-127 pdx 97

9/9/2010

Joyce Toutelli
74yo

5/2010 CMP WNL except glucose 253, WBC 7, HCT 41, PLT 180, UA clear, TSH WNL, A1C 7.9.
Pt was started on Metformin 500mg bid and is happy to report that her blood sugars have ranged 79-127. She is taking Lanoxin 25mb qd, Atenolol 50mg qd, HCTZ 25mg qd and Zestril 20mg qd with BPs ranging 109-127/52-78. She has been quite dizzy saying that there are many days it takes her a few hours to get out of bed. Even then, she may still have some residual dizziness symptoms. Pt denies any colds, coughs, flus, fevers, chills, sweats, ear pain, sore throat, and dysuria. Pt c/o no itchy, runny, eyes & nose nor sneezing. She is quite depressed regarding how her sons treat her and how much money she has given them through the years and yet they still seem to be completely ungrateful about everything she has given them to the point that she cannot rely on them to come mow her lawn for her. She is thinking about simply moving back home to England because, despite Prozac, she is crying daily.
Exam: 109/52 190# (she has lost 10# in 3mo)
HEENT and cardiopulmonary exams benign.

Impression:

Type II diabetes 250.00	Fatigue 780.79
C-spine DDD 722.4	PAF 427.31
CHOL 272.0	Hypertension (overtreated) 401.1
Gout 274.9	DJD Knee 715.16
Gastritis 535.50	Anxiety 300.00
Depression 311	Insomnia 780.52

Plan: Instructed pt to discontinue Atenolol because of hypotension. Continue other meds unchanged. RTC 1mo for interval assessment and BP diary review. Will check A1C at that time, as well. Precautions given for calling/returning w/ positive feedback. Further evaluation / treatment as indicated. RTC prn.

LKM

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07/01/10

4 - Healthcare info...

74yo

Patient started taking Metformin 500mg bid and is happy to report that her blood sugar range has been 93-154, asymptomatic. Unfortunately she has not had this amazing improvement in the way she feels. She continues to have SOB unchanged from her previous, fatigue unchanged from her previous and still feels unsteady on her feet. She has not fallen but is bothered significantly but left shoulder discomfort.

Exam: 128/78

HEENT and cardiopulmonary exams benign. Shoulder has limited ROM because of pain although she can internally and externally rotate her arm and raise it slowly above the horizontal.

Impression:

Type 2 Diabetes 250.00	Left Shoulder OA 715.11
Fatigue 780.79	PAF 427.31
C-spine DDD 722.4	C-spine Strain 847.0
Paroxysmal Atrial Fibrillation 427.31	
CHOL 272.0	Hypertension 401.1
Gout 274.9	DJD Knee 715.16
Gastritis 535.50	Anxiety 300.00
Insomnia 780.52	Depression 311

Plan: Continue current medicines unchanged. RTC one month for interval assessment and blood sugar diary review. If this is stable then we will see her less often because her blood sugars will then be seen on AIC to be stable and well controlled. Precautions given for calling/returning w/ positive feedback. Further evaluation / treatment as indicated. RTC prn.

jrp

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06/03/10

4 - Healthcare inf...

74yo

05/10 CMP WNL except glucose 253. A1C 7.9. WBC 7, HCT 41, PLT 180. UA clear. TSH WNL.
The patient describes how she has been tired and been bothered by polyuria, polydipsia, blurry vision, and anhedonia.
Exam: 148/80 Random Accu-Chek 273 at 2pm
HEENT and cardiopulmonary exams benign.
Impression:

New Onset Type 2 Diabetes 250.02	
C-spine DDD 722.4	C-spine Strain 847.0
Paroxysmal Atrial Fibrillation 427.31	
CHOL 272.0	Hypertension 401.1
Gout 274.9	DJD Knee 715.16
Gastritis 535.50	Anxiety 300.00
Insomnia 780.52	Depression 311

Plan: Explained at length to the patient and her son, showing her labs from previous years, how her levels have been gradually been increasing to their current levels despite dietary efforts on her part. Start Metformin 500mg bid. Pt instructed to continue with prudent diet, weight loss, and regular exercise with positive feedback. RTC one month for interval assessment and blood sugar diary review.

jrp

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05/27/10

4 - Healthcare inf...

74yo

02/09 CMP WNL. A1C 6.1. TSH WNL.
05/09 C-spine MRI showed multi-level DDD changes with facet arthropathy and moderate-to-severe central canal stenosis at C5-6 and mild central canal stenosis at C3-4, C4-5, and C6-7.
Pt consulted with neurologist Dr. Lang on 06/16/09 regarding chronic neck pain and they recommended further studies. Carotid ultrasound showed no significant stenosis and C-spine films in neutral, flexion, and extension views showed retrolisthesis of C5 on C6 and moderate C5-6 DDD. The patient has continued to pursue her State Farm MVA claim but it generally accepted that the majority of her symptoms are preexisting.
She participated in multiple modality South Sound Physical Therapy from 10/09 through 02/10 and had some improvement in neck ROM and discomfort.
She complains of ongoing anxiety, aching left-chest pain, poor energy level and appetite, decreased weight and headaches with excessive sleeping during the day. As a result she has significant insomnia at night and would like a medicine to get her back on her normal sleep cycle.
She is still quite depressed on Prozac 40mg qd.
Exam: 156/87
HEENT and cardiopulmonary exams benign. The patient appears to be sharp and talkative, bright and alert but complains that she has had mental deterioration for the last several months because of her physical condition. She says she is more depressed now and has no ambition.

Impression:		
	Anxiety 300.00	C-spine DDD 722.4
	Depression 311	C-spine Stenosis 723.0
	Hyperlipidemia 272.2	Fatigue 780.79
	Hypertension 401.1	Insomnia 780.52
	DJD Knee 715.16	Gastritis 535.50
	Diet-Controlled Diabetes 250.00	

Plan: Start Wellbutrin SR 150mg bid for additional anti-depression effect.
She has a minimal degree of ROM/ROE with a small amount of discharge present in the EAC so we will give her Augmentin 500mg bid x10 days.
Restart Dalmane 15mg qhs for insomnia to get her back on track regarding sleep. Continue other meds unchanged.
Comprehensive metabolic panel, CBC, TSH, UA and A1C. Will call patient w/ results when received. Precautions given for calling/returning w/ positive feedback. Further evaluation / treatment as indicated. RTC prn.

jrp



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3/9/2010

4 - Healthcare inf...

74yo

Pt has been absent for 3mo. She is continuing to take Indocin 25mg tid and is continuing with multiple-modality PT and massage therapy 3x wk with no further improvement in her MVA neck pain. She still complains of posterior neck pain which radiates up into headache and less shoulder or scapular pain. She still has significantly limited neck ROM in that she can only turn her head 45° to the right and 25° to the left. She mostly uses her mirrors when changing lanes while driving and complains bitterly of significant difficulty in grabbing her seat belt, either with the right hand or the left hand in order to lock it into place. The Soma 350mg tid was ineffective at improving her neck discomfort radiating into the arms.
Exam: 144/82
She has significant limited C-spine ROM both turning her head, leaning her head and looking up. She has no trouble touching chin to chest.
Impression: MVA C-spine strain 847.0 History of moderately severe C-spine spinal stenosis
Plan: Start Robaxin 750mg bid-tid for MVA neck/shoulder spasm/tightness/pain. It does not appear that multiple-modality PT is helping her and I suspect that her moderately severe multilevel C-spine central canal stenosis is more responsible for her pain than her MVA at this point. Will search for other therapy that may gain her either more ROM or comfort. Precautions given for calling/returning w/ positive feedback. Further evaluation / treatment as indicated. RTC prn.

LKM

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MUA

12/10/2009

4 - Healthcare inf...

73yo

Pt is taking Indocin 25mg tid and is participating in multiple-modality physical and massage therapy 3xwk with improvement in her neck pain. She still complains of right neck discomfort radiating into the right shoulder and left-sided neck pain when she turns her head to the left. She is bothered by headaches as well as discomfort down the posterior neck into the upper back. She is tired and depressed all the time because of this relative disability her accident has caused.
5/09 C-spine MRI showed multilevel DDD. She was send to MRI and the neurologist for tingling sensation in the fingers of the right hand. This symptom has not changed in the intervening time. She is taking muscle relaxing medications daily, participating in a home exercise program and is only seeing minimal improvement in her condition generally. She has not reached maximum medical improvement.
Exam: C-spine has fair ROM, limited at the extremes. Palpation of the trapezius musculature does not reveal any trigger points.
Impression: MVA C-spine strain 847.0
Plan: Continue current medications and treatment.
Completed State Farm Insurance Physician's Report form indicating the above. It may take 3-6mos for this pt to reach maximum medical improvement given the slow response we have observed so far. Precautions given for calling/returning w/ positive feedback. Further evaluation / treatment as indicated. RTC prn.

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11/12/09

4 - Healthcare info...

73yo

State Farm MVA

Patient has been participating in multiple modality South Sound Physical Therapy for ongoing neck pain. Her treatment is primarily massage for neck pain due to cervical strain and prognosis is excellent. She has had decreased muscle guarding, pain, and tingling, but has continued symptoms of whiplash from the accident.

The patient still complains of feeling "out of sorts." She is light-headed at night. She still can only turn her head 90 degrees at times and this limits her driving because she cannot check lanes adequately. She is looking forward to an appointment with neurologist, Dr. Lang, with whom she has worked before regarding right hand tingling. She complains because her upper-shoulder pain radiating into neck pain and headache does not allow her to make her bed, vacuum, go grocery shopping by herself, or clean her house. She is very frustrated with this sudden change from her previous independence.

Exam: Afebrile

Patient does have decreased ROM of the neck. Palpation across the upper shoulders creates discomfort but does not reveal any trigger points. Patient appears to be tired and is not her usually animated self because of decrease energy level.

Impression: MVA C-spine Strain 847.0

Plan: Continue home exercises and physical therapy massage.

Wrote a note requesting that she have in-home-care services two to three hours a day, two to three days a week for one to two months while she recovers.

Start Soma 350mg qhs-tid for neck and shoulder spasm pain. RTC two to three weeks for interval assessment. Precautions given for calling/returning w/ positive feedback.

jrp

Harris, MD

DATE	AGE	TEMP	RESP	PULSE	BP	WT	PAIN	TOB	CHIEF COMPLAINT	COUNSEL
6-26-06	70		18	76	134/96	W 95 ~~96~~		NO	High BP	
9-27-06	70		20	80	143/78	NO		NO	Test Results	
8-24-06	70		18	82	140/86			¢	f/u Lexapro	
9-27-06	70		22	82	131/63	NO		¢	f/u Lexapro	
11-16-06	70		20	71	131/71	NO		¢	paperwork, flu shot	
1-15-07	70		21	71	100/84	NO		¢	√ BP, med √, dizzy, √ Ⓡ third toe	
9/30/07	70		20	74	147/74	NO			Ⓡ foot swelling	
2/13/07	71		18	76	129/72	NO		¢	f/u Indocin, ↓ meds	
4-3-07	71		18	74	126/64	NO		¢	Ⓡ knee pain Awakens HER Feels unwell. Pulls self. Helps. Dizziness	
5-10-07	71		18	Reg 72	147/88	NO Cough			Ⓡ ear Infection, fatigue Some drainage, odor Seeking Hours Eyes Good R Tympanum bulging	
10-10-07	71		16	66	131/88				HA EKG? Medication f/u, Go over Rx's Blurry spot	
11-14-07	71		20	Reg 78	130/76				unable to Sleep. dizzy	
3-27-08	72		67	18	134/71			¢	Not x2 BS 248 BPV, medication RFUA: Gluc ††† Nitr †††	
4-23-08	72		59	16	130/60			¢	BS f/u 75-167 Pox 97	
5-22-08	72		92		145/89			♀	F/u BS 100-129 96%	
6/5/08	72			61	137/78				↓0 over meds HIVES 90-104 12%	
10/15-08			18	61	126/72			¢	Fatigued, "doped up", tired, unsteady, "slurring" Talk c pt's son re: meds words 90-107	
7/24-08			18	99	136/85			¢	BS f/u.	
8/27-08			16	65	152/85				foot	
12/23-08	72		18	72	147/80	205		¢	Rx's, flu shot 87-105	
2-9-09	72		18	70	144/79	no			f/u dentist, 87-102	
5/13-09	73		18	60	140/68	NO		¢	R. MK PM. MM x2w. WHITE HAND + ARM TINGLING w/ DRIVING, ARM REST pins & needles in R hand, ~~fatigue~~ SWELLING	
6/16	73				149				ASSISTED AT 8PM 12h LATER → MK PM → HANDS TINGLE	

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10/08/09

4 - Healthcare inf...

73yo

02/09 CMP WNL. A1C 6.1. TSH WNL.
05/09 C-spine MRI showed multi-level DDD with severe central canal stenosis at C5-6 and mild spinal canal stenosis at C3-4, C4-5, and C6-7.
She saw neurologist, Dr. Lang, 06/15/09, regarding right hand tingling. Flexion/extension C-spine films showed retrolisthesis of C5 on C6 with ongoing, moderate DDD at that level which was treated conservatively. Incidental carotid ultrasounds showed no hemodynamically, significant, bilateral carotid plaque, although a bruit was heard. Patient is happy to report that, just with conservative care, her neck pain significantly improved until earlier this week. She hit a deer while driving on the ~~road~~ and it barely bumped her car. Then, twelve hours later, she was rear ended while taking money out of the ATM machine causing her car to slam into the pole. This did jar her and renewed her neck pain and restarted her hand tingling. She has also had some left-chest aching discomfort but denies associated SOB, dizziness, sweats, or radiating discomfort into her left arm.
She is quite upset about all of this and feels that Prozac 20 mg qd is inadequate to relieve her depression symptoms.
Blood pressure is well controlled on Atenolol, HCTZ, and Zestril. She has not had any racing heart or skipped beats on Lanoxin.
It has been a while since she had blood work update on Simvastatin.
She has not been taking Prilosec lately, and she has noticed that when she stops that medicine, she usually has a bit more stomach upset, heartburn, and sometimes this left-chest aching.
Exam: 16 57 149/83 205# Nonsmoker
WNWD elderly WF in NAD; pleasant, cooperative, talkative. EOMI, PERRL, TMs clear, pharynx benign. Teeth in adequate repair. No cervical nodes nor JVD. Heart RR w/o M. Lungs CTAT. Abd soft, flat, NT to palp w/o HSM nor masses; BS+. Extr FROM w/ strong, symmetrical pulses in the lower extremities; no CCE. Neck has generally decreased ROM. She has a III/VI systolic heart murmur.

Impression:	C-spine DDD 722.4	Paroxysmal Afib 427.31
	C-spine Stenosis 723.0	Bilateral Hip Replacements
	CHOL 272.0	Hypertension 401.1
	MVA C-spine Strain 847.0	Gout 274.9
	DJD Knee 715.16	Gastritis 535.50
	Diet Controlled Diabetes 250.00	
	Anxiety Disorder 300.00	Insomnia 780.52
	Depression 311	

Plan: Increase Prozac to 40mg qd.
Restart Prilosec 20mg qd-bid for GERD/chest-aching symptom. Continue other meds unchanged.
Will send the patient to multiple modality physical therapy for renewed neck discomfort and hand tingling.
Sent for interval FLP, A1C, and CMP. Precautions given for calling/returning w/ positive feedback. Further evaluation / treatment as indicated. RTC prn.
Nature of the presenting problem: Moderate severity if not treated.
Counseling/Coordination of care: Discussion regarding impressions, prognosis, risk/benefits, treatment options, follow-up, patient education: 15-25minutes.
Medical Decision-Making: Multiple diagnoses w/ extensive amount of data to be reviewed, moderate complexity of decision making and moderate morbidity.

jrp

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05/13/09

4 - Healthcare info...

73yo

02/09 CMP WNL except Glucose 120. A1C 6.1. TSH WNL.
Patient had a trip to Scotland and enjoyed herself but, after pulling luggage through the airport, ended up with some right neck pain. This has occurred off and on for the past two weeks and for the past few days she has had her entire right arm and hand tingling. This is especially bothersome when she drives, rests her arm on an armrest, lays her arm on an armrest, or sleeps. This is a pins-and-needles sensation more than it is true numbness. She is concerned because she has three sisters who ended up with neck surgeries for various similar symptoms.
Exam: 18 60 140/68 105#
Neck has full ROM. Shoulder, elbow, hand, and finger exam are unremarkable. She cannot tell any difference in sensation between the ulnar and radial sides of the hand nor top or bottom regarding sensation.
Impression: C-spine DDD With Radiculopathy 722.4
Plan: Will send the patient for C-spine MRI. Precautions given for calling/returning w/ positive feedback. Further evaluation / treatment as indicated. RTC prn.

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2/09/09

4 - Healthcare info...

73 yo

11/08 mammogram within normal limits.
Patient is looking forward to getting a full upper extraction with dental implants, and then she is going to go on a trip to Scotland for a vacation.
She is taking Metformin 500mg bid with resulting blood sugar range 87-102, asymptomatic.
Depression symptom are well controlled with Prozac 20mg qd. She is worried that her hair is falling out, but blood work last year showed no imbalance of thyroid, blood count, nor chemistry profile.
She is taking Atenolol 50mg qd, HCTZ 25mg qd, Zestril 20mg qd and Digoxin 0.25 mg qd with good control of BP. Pt denies any chest pain, shortness of breath, palpitations, racing heart, and skipped beats.
Complete Review of Systems otherwise minimized.
PMH: 4/08 CMP WNL except glucose 125. Glycohemoglobin 8.3, cholesterol 136, triglycerides 118, HDL 31, LDL 81, WBC 8, HCT 43, PLT 226, TSH within normal hmits.
Exam: 18 70 144/79 (Patiem refused weight). Nonsmoker.
WNWD obese WF in NAD; pleasant, cooperative, talkative. EOMI, PERRL, TMs clear, pharynx benign. She has many missing teeth. No cervical nodes nor JVD. Heart RR w/o M. Lungs CTAT. Abd soft, flat, NT to palp w/o HSM nor masses; BS+. Extr FROM w/ strong, symmetrical pulses in the lower extremities; no CCE.

Impression:	Type II Diabetes	Depression
	CHOL	Hypertension

Plan: Refilled Prozac 20mg qd and Lanoxin 0.25 mg qd. Continue other meds unchanged.
Comprehensive metabolic panel, CBC, TSH, FLP. Will call patient w/ results when received. Further evaluation / treatment as indicated. RTC prn. Precautions given for calling/returning w/ positive feedback.

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[redacted]

10/23/08

72 years old

Blood sugars are 87-105 with diet control. No episodes of hypoglycemia.
Gout is well controlled with Indocin 25mg tid. Blood pressure is well controlled on atenolol 50mg, hydrochlorothiazide 25mg qd, and Zestril 20mg qd. Pt denies any chest pain, shormess of breath, palpitations, racing heart, and skipped beats.
The patient is interested in pursuing the finding of carotid bruit from the last visit. No signs of transient ischemic attack/ stroke. Complete Review of Systems otherwise minimized.
Exam: 18 72 147/80 205# (lost 50# in two years).
Cardiopulmonary exam benign. No LE edema. The patient has multiple missing and carious teeth and is deciding whether or not to get new teeth, buy a new house, or take a trip to England.

Impression:	CHOL 272.0	Gout 274.9
	Hypertension 401.1	Insomnia

Plan: Start Lunesta 2mg to 3mg qhs for insomnia. Continue other meds unchanged.
Sent for carotid ultrasound to evaluate carotid bruit. Consent form signed and flu shot administered with no reaction. RTC prn.

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08-27-08

4 - Healthcare informati...

72 years old.

Ms. Tuitele came in today stating that she has had a flare up of her gout. She complains of pain in the right big toe and the 3rd digit of her right foot. The patients states that when she ambulates and bears weight that it does cause her some marked discomfort also. The foot she says feels hot to the touch.

Exam: 152/85 65 16.

Examination of her heart detects a slight systolic murmur. In her neck there was a small carotid bruits noted over the right carotid bruits which is approximately 1/6. Patients show me that she does have some erythema over the right foot and there is no evidence of any edema, it is somewhat warm to the touch, the radial pulse was still in tact. The first digit showed some marked erythema also and was painful when I palpated in that area. The normal phalanx of the 3rd digit of the right foot also shows some redness and their doesn't appear to be any swelling.

Impression: Gout Right Foot
Carotid Bruits
Heart Murmur

Plan: I would like to initiate treatment with Colchicine 0.6 mg tabs 1 every 6 hours for pain relief ~~for~~ until loose stool #12 no refills. She has Naprosyn at home that she will use 500 mg 1bid. RTC 1 month prior to the patient going on vacation to Scotland.

WKH

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07-24-08

1 - DOH Licensee Hea...

72 years old.

Patient came in today to recheck her blood sugar levels with a list of blood sugars levels that she has had taken at home for the month of July until now and the range in the low 90's lowest being 88 and high 103. Patient also has been seen on 6/18/08 for a UTI since that time she states that she has taken a treatment of Macrobid and says that her UTI has resolved and she is asymptomatic and afebrile.

Impression: Hyperglycemia UTI Resolved

Plan: Continue with current Regimen, medications, and RTC 1 month or on a prn basis.

Nature of the presenting problem: Moderate severity if not treated.

Counseling/Coordination of care: Discussion regarding impressions, prognosis, risk/benefits, treatment options, follow-up, patient education: 10-15 minutes.

Medical Decision-Making: Limited diagnoses w/ moderate amount of data to be reviewed, moderate complexity of decision making and moderate morbidity.

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06-18-08

4 - Healthcare informati...

72 years old.

Pt c/o urinary burning, pain, hesitancy, frequency, urgency, nocturia, odor, and residual sensation for the past several days. Patient has felt fatigued, tired, unsteady, and has been slurring her words. Her sugars have ranged 90-107.

Exam: 18 76 126/72.

No CVAT. Urine dipstick positive for WBC's and RBC's. Abdomen is soft, flat, NT to palp, w/ no HSM nor masses; BS+.

Impression: UTI

Plan: Macrobid x10d. Other supportive measures including Pyridium 200 mg tid with positive feedback. RTC prn.

Nature of the presenting problem: Moderate severity if not treated.

Counseling/Coordination of care: Discussion regarding impressions, prognosis, risk/benefits, treatment options, follow-up, patient education: 10-15 minutes.

Medical Decision-Making: Limited diagnoses w/ moderate amount of data to be reviewed, moderate complexity of decision making and moderate morbidity.

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06-05-08

4 - Healthcare informati...

72 years old.

Patient had an episode of hives last week which has resolved with OTC antihistamines.
Patient has been paying attention to prudent diet and regular exercise with resuhing blood sugar range 90-104 with weight loss.
Patient is considered about her medications and says that she is taking two NSAIDs and two SSRIs. It turns out that she had some old bottles of Prozac and has been taking Lexapro but has found that the Lexapro is causing a side effect. She takes Diclofenac but has reserved Indocin for when she has gout, otherwise, she is doing well on HCTZ, Atenolol, Zocor, Zestril, Digoxin, Valium prn, Midrin prn, and Prilosec prn.
Exam: 18 61 137/78.
Patient pleasant, cooperative, talkative; sits comfortably in chair. Brief exam unchanged from previous visit.

Impression:	Type 2 Diabetes	Insomnia
	Non-Insulin Dependent	Hives
	Diabetes Well Controlled	

Plan: DC Diclofenac, and continue Indocin for arthritis and gout.
DC Lexapro (intolerant side effect). Continue Prozac 20 mg qd for mood management. Continue other meds unchanged. Other supportive measures including antihistamines for hives which has now resolved with positive feedback. RTC prn. Precautions given for calling/returning w/ positive feedback.
Nature of the presenting problem: Moderate severity if not treated.
Counseling/Coordination of care: Discussion regarding impressions, prognosis, risk/benefits, treatment options, follow-up, patient education: 10-15 minutes.
Medical Decision-Making: Limited diagnoses w/ moderate amount of data to be reviewed, moderate complexity of decision making and moderate morbidity.

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5/22/08

4 - Healthcare inf...

72yo

April 2008 comprehensive metabolic panel within normal limits except glucose 125. Glycohemoglobin 8.3. Cholesterol 136, triglyceride 118, HDL 31, LDL 81. WBC 8.4, HCT 43, PLT 226. TSH within normal limits.

Patient is happy to report that her blood sugars have ranged 100-129, asymptomatic; and that she never did start taking metformin 500 mg b.i.d.

Patient reports that she was shopping in a scooter at Wal-Mart when she was bumped by a worker. This is significantly jarred her, and ever since that time, she has been complaining of bilateral hip discomfort radiating into the thighs. She has bilateral hip replacements, and says that these have been quite uncomfortable ever since. Complete Review of Systems otherwise minimized.

Exam: 16 54 145/89 (patient refuses weight).

Patient ambulates easily with a cane with her usual gait. Brief exam unchanged from previous visit.

Impression: Type 2 Diabetes Controlled/Non-Ins-Dependent
Musculoskeletal Bilateral Hip Pain
Status Post Bilateral Hip Replacements

Plan: Encouraged the patient to continue with her current diet, exercise, and weight loss program with positive feedback.

She is having significant relief of her hip pain with Naprosyn 500 mg b.i.d. Precautions given for calling/returning with positive feedback.

RTC one month for interval assessment and blood sugar diary review. We will draw her glycohemoglobin test again in July 2008; and if it is poorly controlled, then we will initiate metformin therapy. Further evaluation and treatment as indicated.

Nature of the presenting problem: Moderate severity if not treated.

Counseling/coordination of care: Discussion regarding impressions, prognosis, risk/benefits, treatment options, follow-up, patient education: 10-15 minutes.

Medical Decision-making: Limited diagnoses with moderate amount of data to be reviewed; moderate complexity of decision-making and moderate morbidity.

This document was created using voice-recognition software.

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04-23-08

4 - Healthcare informatio...

72 years old.

Patient went to see her new great grandchild in Texas earlier this month and has an convoluted family stress story to tell. Her son is divorced and his ex wife is now involved in a lesbian relationship, but unfortunately her lover went back to her husband causing family turmoil in Texas regarding the grandchildren and now the great grandchild. The patient also has significant delays in her travels and that her flights were delayed for 2 days due to cancellations across the country. Needless to say, she has been quite stressed and feels that this has contributed significantly to elevated blood sugars despite her good efforts with prudent diet and diabetic lifestyle. Her blood sugars range 75-167. Because of her anxiety she has had some insomnia. She also mentions worsening to urinary incontinence and gout incidentally. She would like refills on blood pressure medicine. Pt denies any chest pain, shortness of breath, palpitations, racing heart, and skipped beats.

Exam: 16 59 130/60. (Patient refuses weight).

Patient pleasant, cooperative, talkative; sits comfortably in chair. Brief exam unchanged from previous visit.

Impression:	Adjustment Reaction	Diet Controlled Type 2 Diabetes
	Insomnia	Gout
	Hypertension	UTI ~~Result~~ Resolved

Plan: Restart Valium 10 mg qhs for insomnia since she has not had good luck with Xanax helping with insomnia. Refilled Allopurinol, Indocin, and Zestril. RTC 1 month for interval assessment. Precautions given for calling/returning w/ positive feedback.

Nature of the presenting problem: Moderate severity if not treated.

Counseling/Coordination of care: Discussion regarding impressions, prognosis, risk/benefits, treatment options, follow-up, patient education: 10-15 minutes.

Medical Decision-Making: Limited diagnoses w/ moderate amount of data to be reviewed, moderate complexity of decision making and moderate morbidity.

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03-27-08

4 - Healthcare informatio...

72 years old.

Patient is upset with her pharmacy and is switching all medicines to a different one because of continued difficulties. She is doing well on current medications only complaining that she has racing thoughts that keep her awake at night and disrupt her sleep onset. She also has nocturia x2. Pt denies urinary burning, pain, hesitancy, frequency, urgency, odor, & residual sensation. She says that she has been feeling tired lately. Complete Review of Systems otherwise minimized.

Exam: 18 67 134/71 (Refuses weight).

Patient ambulates independently with a cane, complaining about the snow and irregular walking surfaces outside. Abdomen is soft, flat, NT to palp, w/ no HSM nor masses; BS+. No CVAT. Urine dipstick strongly positive for glucose and nitrates. Random Accu-check 248.

Impression:
- UTI
- Fatigue
- New onset type 2 diabetes
- Chronic renal failure

Plan: Start Bactrim DS bid x1w for UTI.

Refilled Prozac, HCTZ, Atenolol, Zocor, Zestril, Digoxin, Diclofenac, Ambien, and started Xanax 0.5 mg qhs to quite her racing thoughts.

Provided multiple handouts on diabetes, strongly encouraging to her to check blood sugars on a regular basis. Sent her for FLP, CMP, CBC, and TSH. RTC 2 weeks for interval assessment and blood sugar diary review. Precautions given for calling/returning w/ positive feedback. Further evaluation / treatment as indicated. RTC prn.

Nature of the presenting problem: Moderate severity if not treated.

Counseling/Coordination of care: Discussion regarding impressions, prognosis, risk/benefits, treatment options, follow-up, patient education: 15-25minutes.

Medical Decision-Making: Multiple diagnoses w/ extensive amount of data to be reviewed, moderate complexity of decision making and moderate morbidity.

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11-14-07

4 - Healthcare info...

71 years old

Pt says that Prozac has done a nice job of smoothing her mood at 20mg qd. She worries though that it may be too sedating for her, because at times she is busy in the morning.
She had itching all over to the point that she is scratching herself to pieces and would like a medicine for itching.
Pt complains of insomnia saying that she may lie awake for hours at night and would like a medicine for this. She has been on Ambien 12.5mg qhs before, but it left her with some morning residual sedation.
Exam: 20 78 130/76
Cardiopulmonary exam benign. No LE edema. Skin exam is clear.

Impression:	Depression	Insomnia
	Itching	HTN

Plan: Start Allegra 180mg qd for skin itching.
Restart Ambien CR 6.25mg qhs for insomnia. Continue other meds unchanged. Precautions given for calling/returning w/ positive feedback. Further evaluation / treatment as indicated. RTC prn.
Nature of the presenting problem: Moderate severity if not treated.
Counseling/Coordination of care: Discussion regarding impressions, prognosis, risk/benefits, treatment options, follow-up, patient education: 10-15 minutes.
Medical Decision-Making: Limited diagnoses w/ moderate amount of data to be reviewed, moderate complexity of decision making and moderate morbidity.

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10-10-07

4 - Healthcare inf...

71 years old

Ms. 4 - Healt... is having mood swings, depression, anxiety, palpitation, indigestion, insomnia, poor appetite, and feelings of being overwhelmed. This contributes to gastritis which is also worsened by her NSAIDS, which she says helps for arthritis pain. She has been on Prozac in the past, but stopped it in 6/06 because it had lost its effectiveness. She only took Lexapro for a few months, but stopped because of excessive sedation. Since that time she has taken Valium 5mg bid, but says that it has been ineffective at relieving anxiety symptoms.

Her sons accompany her to her visit today confirming many of her complaints at the same time that she says they are supportive, she also admits that they have contributed to a significant amount of stress in her life with there own personal problems. Patient complains of difficulty sleeping, poor interests/hobbies/enjoyment, guilty feelings, poor energy level, poor concentration, poor appetite, poor libido, and depression.

Otherwise the patient is doing well on Atenolol, HCTZ, Zocor, Lisinopril, Digoxin, Diclofenac, and Prilosec. Complete Review of Systems otherwise minimized.

Exam: 16 66 131/88 (pt refuses weight)

Pt is somewhat upset during our visit today. While she describes all the family and mental stresses that she has been experiencing in the last several months.

Impression:	Anxiety/Depression	HTN
	CHOL	Gastritis
	Multiple OA	

Plan: Consent form signed and flu shot administered with no reaction

I explained to the patient and her sons that the majority of her symptoms maybe related to untreated anxiety/depression and that a restart of Prozac 20-40mg qd would not be unreasonable as a first step to reversing a lot of these symptoms which have recurred. RTC 1 month for interval assessment. Continue other meds unchanged. Precautions given for calling/returning w/ positive feedback. Further evaluation / treatment as indicated.

Nature of the presenting problem: Moderate severity if not treated.

Counseling/Coordination of care: Discussion regarding impressions, prognosis, risk/benefits, treatment options, follow-up, patient education: 10-15 minutes.

Medical Decision-Making: Limited diagnoses w/ moderate amount of data to be reviewed, moderate complexity of decision making and moderate morbidity.

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5/10/2007

4 - Healthcare inf...

71 years old.

EKG from January 2000 sevenths showed atrial fibrillation, but since the patient was put on digoxin she has had no further episodes of irregular heartbeat.

Last month, the patient was complaining of dizziness and seeing flashing lights. She simply has been noticing these bright flashing lights occurring in her vision every now and then, and during simple activities such as shopping. Patient denies any trauma, injuries, or accidents. She went to the eye doctor and had a full eye exam, and there was found to be no specific retinal detachment. She is going back for glaucoma check next week. CAT scan of the head showed no acute intracranial abnormality that would explain her symptoms. She still has some difficulty describing her sensation, but admits that she has been under it a significant amount of stress with her sons, selling her house, and other things. She describes moderate headaches that are associated with these vision changes, occasional nausea, and photophobia. She has never had migraine headaches diagnosed in the past.

April 2007 right knee fihns showed severe degenerative changes of the knee in the patellofemoral compartment with joint space narrowing and spurring present.

Otherwise the patient is doing well on HCTZ, atenolol, Zocor, Zestril, and Diclofenac. Complete Review of Systems otherwise minimized.

Exam: 18 72 (pulse regular) 147/88 (patient refuses weight)

Patient ambulates with a cane because of DJD knee pain. HEENT and cardiopulmonary exams benign except she has a minimal amount of moisture in the right external auditory canal; there is no associated EAC swelling, erythema, nor odor. She reports having a red, itchy rash under the breasts.

Impression:	Hypertension	Breast Intertrigo
	Hyperlipidemia	Paroxysmal Atrial Fibrillation
	DJD Knee	Tension Headaches

Plan: Start Midrin tabs q.i.d. as needed for severe headaches. Discussed the possibility of migraine headaches, but it seems highly unlikely in this age of patient. There are times that she has symptoms without headache, so it is possible that this may represent migraines without headache, but I feel that is highly unlikely. I reassured the patient about the benign nature of her exam today, her CAT scan results, and her eye exam. Precautions given for calling/returning with positive feedback. Further evaluation and treatment as indicated.

Start Lotrisone cream to breast intertrigo b.i.d. until clear. Continue other current medications unchanged.

Provided a note indicating that the patient has been seen in the family medicine clinic for multiple medical issues. It is recommended that her daughter-in-law live nearby so that she may attend to the patient's needs in a caregiving way.

Nature of the presenting problem: Moderate severity if not treated.

Counseling/coordination of care: Discussion regarding impressions, prognosis, risk/benefits, treatment options, follow-up, patient education: 10-15 minutes.

Medical Decision-making: Limited diagnoses with moderate amount of data to be reviewed; moderate complexity of decision-making and moderate morbidity.

This document was created using voice-recognition software.

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Fax: 360-528-4643

4/3/07

4 - Healthcare inf...

71yo

The patient is c/o worsening right knee pain that awakens her at night. She has not rested but she is also not taken Indocin as prescribed. She has only been using prn.
She has significant right third toe gout pain and her tophus is coming out of the skin.
The patient generally feels unwell c/o acid peptic complaints. She takes Alka Seltzer every day and says that it helps but she still has some nausea and dizziness. Valium helps with anxiety.
Exam: 18 74 126/64
Knee exam: No bruising, discoloration, deformity, or swelling. Nontender/full ROM. Ligament testing shows no significant/abnormal laxity. No joint line nor patella manipulation tenderness.

Impression:	Right knee DJD	Gastritis
	Gout	Anxiety

Plan: Encouraged the patient to take Indocin 25mg tid. Start Prilosec 20mg qd for gastritis. Start Allopurinol 100mg qd for gout.
Sent the patient for right knee films. Precautions given for calling/returning w/ positive feedback. Further evaluation / treatment as indicated. RTC prn. Nature of the presenting problem: Moderate severity if not treated.
Counseling/Coordination of care: Discussion regarding impressions, prognosis, risk/benefits, treatment options, follow-up, patient education: 10-15 minutes.
Medical Decision-Making: Limited diagnoses w/ moderate amount of data to be reviewed, moderate complexity of decision making and moderate morbidity.

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2/13/07

4 - Healthcare info...

71yo

Ms. 4 - Healt... is taking Digoxin 0.25mg qd and is happy to report that she has had no more episodes of palpitations attributable to atrial fibrillation. She has had no dizziness or side effect on the medication. She has no more leg swelling and no more SOB.

She continues to c/o multiple joint arthritis saying that Indocin did not work as well as Diclofenac. Complete Review of Systems otherwise minimized.

Exam: 18 76 129/72

Cardiopulmonary exam benign. No LE edema.

Impression: Paroxysmal atrial fibrillation Right knee DJD

Plan: Refilled Digoxin 0.25mg qd for PAF. Continue other meds unchanged. Precautions given for calling/returning w/ positive feedback. Nature of the presenting problem: Moderate severity if not treated. Counseling/Coordination of care: Discussion regarding impressions, prognosis, risk/benefits, treatment options, follow-up, patient education: 10-15 minutes.

Medical Decision-Making: Limited diagnoses w/ moderate amount of data to be reviewed, moderate complexity of decision making and moderate morbidity.

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1/30/07

4 - Healthcare inf...

70yo

1/07 CMP WNL except BUN 25 and Creatinine 1.8. WBC 8, HCT 44, PLT 274, TSH WNL.
For the past several days the patient has had exquisite discomfort in the right great toe radiating into the medial foot. This pain was so significant that she had to hold her foot out from under the seats. She has had some right foot swelling.
Exam: 20 74 147/74 (Pt refuses weigh in)
She has a 5x7mm tophus on the right third toe. The right great toe is somewhat reddened but not particularly hot.
Impression: Right great toe gout Right third toe tophus
Plan: Start Indocin 25mg tid. If she does not have improvement with this then we will consider Colchicine or Allopurinol. Precautions given for calling/returning w/ positive feedback. Further evaluation / treatment as indicated. RTC prn. Nature of the presenting problem: Moderate severity if not treated.
Counseling/Coordination of care: Discussion regarding impressions, prognosis, risk/benefits, treatment options, follow-up, patient education: 5-10 minutes.
Medical Decision-Making: Single diagnosis w/ moderate amount of data to be reviewed, low complexity of decision making and moderate morbidity.

W Kirk Harris, MD

CARE MEDICAL & REHABILITATION EQUIPMENT
3430 Pacific Avenue SE, Suite A5
Olympia, Washington 98501
Phone: (360) 459-1520
Fax: (360) 570-5775

WHEELCHAIR PRESCRIPTION

Date of Birth: 4 - Healthc...
ICD-9 Code/Diagnosis: 715.09
Estimated Length of Need (months): 99 MONTHS
Lifetime = 99 months DSHS = 1 to 6 months

Face to Face Exam Completed:

Height: 64 Weight: 250

Date: 10/08/2006
Patient: 4 - Healthcare information rea...
HICN #: 3 - Healthca...A

Please confirm the following information:	YES	NO	N/A
Can the patient's mobility deficit be resolved safely with a cane or walker?	☐	X	☐
Will the patient's home environment accommodate the use of a wheelchair?	X	☐	☐
Is the patient able to safely propel a manual wheelchair?	X	☐	☐
Does the patient's caregiver require the use of a manual wheelchair to assist the patient?	☐	X	☐
Does the patient require a lower height because of short stature or to enable the patient to place his/her feet on the ground for propulsion?	☐	X	☐
Is the patient unable to propel a standard wheelchair?	☐	X	☐
Can the patient self propel a lightweight wheelchair?	☐	☐	X
Does the patient engage in frequent activities that cannot be performed in a standard or lightweight wheelchair?	☐	X	☐
Does the patient require a seat width, depth or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair?	☐	X	☐
Is the equipment needed for mobility solely for use outside of the home?	☐	X	☐
How many hours per day does the patient spend in a wheelchair?	10 hours		
Does the patient have sufficient strength and sitting stability to safely operate a power scooter?	☐	☐	X
Does the patient require features that are not available in a scooter, such as special seating and positioning, an alternative control device, or a lower seat transfer height?	☐	☐	X
Is the patient able to safely operate a power wheelchair?	☐	☐	X

Equipment Ordered:
HEAVY DUTY WHEELCHAIR WITH FOOTREST

Physician: DR W KIRK HARRIS MD
Address: 6981 LITTLEROCK ROAD SW STE 101
TUMWATER WA 98512
Phone: 360-943-3633

License #: MD00028579
State ID#: 7901150
UPIN: E29955
Fax: 360-528-4643

Physician Signature

2-16-07
Date

FAXED 2/16/07

CM-141

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Fax: 360-528-4643

1/15/2007

4 - Healthcare inf...

70 years old.

For the past week, the patient says that she has felt palpitations with some associated dizziness. She denies any specific chest pain, heaviness, or shortness of breath. Blood pressures have been in good control on HCTZ 25 mg q.d., atenolol 50 mg q.d., and Zestril 20 mg q.d.

She has a new swollen spot on her right third toe that she is concerned about. Patient denies any trauma, injuries, or accidents. The spot is only red and slightly swollen, but not hot nor painful. Patient denies any colds, coughs, flus, fevers, chills, sweats, ear pain, sore throat, and dysuria. Pt denies any runny/itchy eyes & nose with sneezing. Patient denies any urinary burning, pain, hesitancy, incontinence, sexual dysfunction, frequency, urgency, nocturia, hematuria, and residual sensation. Patient denies any constipation, diarrhea, or blood in stool. Complete Review of Systems otherwise minimized.

PMH: January 2004. BMP within normal limits. WBC 7, HCT 43, PLT 285.

July 2004 cholesterol 299, triglyceride 257, LDL 209, HDL 39, and LFTs within normal limits on Lescol.

April 2005 cholesterol 218, triglyceride 236, LDL 137, HDL 34.

Exam: 21 71 100/84 (patient refuses weight).

Well nourished, well developed, obese, white female in no acute distress; pleasant, cooperative and talkative. EOMI, PERRLA. TMs clear. Pharynx benign. Teeth in poor repair. No cervical nodes nor JVD. Heart has an irregularly irregular rhythm with no murmur. Lungs CTAT. Abdomen soft, massively obese, nontender to palpation with no HSM nor masses; BS+. Extremities FROM with strong symmetrical pulses throughout; no CCE. EKG shows atrial fibrillation with rapid ventricular response with aberrant conduction and PVCs (rate 107).

Impression:
- New Onset Atrial Fibrillation
- Hypertension
- Obesity
- Hyperlipidemia

Plan: Discussed atrial fibrillation at length with the patient with positive feedback. Start digoxin 0.25 mg q.d. go for rate and rhythm control. Comprehensive metabolic panel, CBC, TSH. Will call patient with results when received. Further evaluation/treatment as indicated.

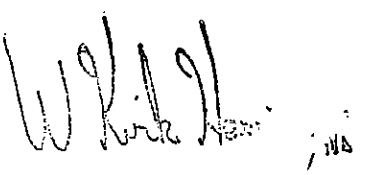
Start Valium 5 mg b.i.d. p.r.n. anxiety. Precautions given for calling/returning with positive feedback.

Nature of the presenting problem: Moderate severity if not treated.

Counseling/coordination of care: Discussion regarding impressions, prognosis, risk/benefits, treatment options, follow-up, patient education: 10-25 minutes.

Medical Decision-making: Multiple diagnoses with extensive amount of data to be reviewed; moderate complexity of decision-making and moderate morbidity.

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11/16/06

4 - Healthcare info...

70yo

Ms. 4 - Heal... is doing well on HCTZ, Atenolol, Zocor, Zestril, Diclofenac, and Lexapro but complains that Valium is no longer working for insomnia. She would like to try a different medication.

Pt has been bothered by some malodorous discharge from the right ear canal. This is an ear that she has had surgery on, but she has not had a significant amount of infections with it.

Exam: 20 71 137/77

HEENT and cardiopulmonary exams benign except she has purulence and odor in the right external auditory canal.

Impression:	Right otitis exterma	HTN
	Cholesterol	Depression
	Insomnia	

Plan: Augmentin 500mg bid x 10d.

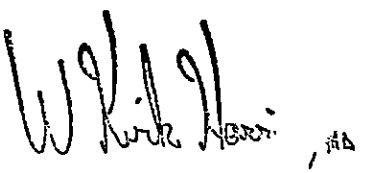
DC Valium (ineffective for insomnia). Start Ambien CR 12.5mg qhs. Continue other meds unchanged. Consent form signed and flu shot administered with no reaction. **RTC 1mo for interval assessment.**

Precautions given for calling/returning w/ positive feedback. Further evaluation / treatment as indicated.

Nature of the presenting problem: Moderate severity if not treated.

Counseling/Coordination of care: Discussion regarding impressions, prognosis, risk/benefits, treatment options, follow-up, patient education: 10-15 minutes.

Medical Decision-Making: Limited diagnoses w/ moderate amount of data to be reviewed, moderate complexity of decision making and moderate morbidity.



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9/27/2006

4 - Healthcare inf...

70 years old.

Patient took Lexapro 5 mg q.d. for another month, but then said that she was able to tolerate the 10 mg dose without excessive sedation. She is very pleased with the combination of Valium and Lexapro, and would like to continue these medications. She describes some ongoing family stressors regarding her boys and her sisters, but minimizes these issues.

She's otherwise doing well on HCTZ, atenolol, Zocor, Zestril, and diclofenac. Complete Review of Systems otherwise minimized.

Exam: 22 82 131/63.

Brief exam unchanged from previous visit. Patient has some mild moist eyes, but denies any specific seasonal allergy symptoms.

Impression: Depression
Moist Eyes
Hypertension
Overweight/Deconditioning

Plan: Reassured the patient that her moist eyes are probably simply just a reaction to some mild, seasonal irritant. Precautions given for calling/returning with positive feedback.

Will continue current medicines unchanged, with the patient deciding whether she needs to continue on the 5 mg q.d. of Lexapro or if she can tolerate the 10 mg q.d. dose.. Further evaluation and treatment as indicated.

Nature of the presenting problem: Moderate severity if not treated.

Counseling/coordination of care: Discussion regarding impressions, prognosis, risk/benefits, treatment options, follow-up, patient education: 10-15 minutes.

Medical Decision-making: Limited diagnoses with moderate amount of data to be reviewed; moderate complexity of decision-making and moderate morbidity.

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8/24/06

4 - Healthcare inf...

70yo

Ms. 4 - Healt... says that Lexapro seems to be too strong in that it causes excessive sedation. She is very depressed about her current situation and realizes that she needs an antidepression medicine but just cannot seem to get pas the sedation side effect of this medicine.

She has taken Valium 10mg qhs and says that it helped with sleep for about 5 hours but gives her very vivid dreams. She has not experimented with decreased doses of either of these meds.

Otherwise, she is doing well on HCTZ, Atenolol, Zocor, Zestril, and Diclofenac.

The pt was able to spontaneously speak for about 10-15 minutes straight about her laid back son, Sean, her difficult son, Greg, her 4 grandsons, Greg's ex-wife who has turned lesbian, her alcohol late Air Force Agent Orange-infected husband who died 2-3 years ago, strange relations with her sisters, etc. The most important of these is that she has moved to this area to be closer to her grandchildren and yet still feels displaced from her more comfortable Southern California home.

Exam: 18 82 140/88

Pt seems somewhat distressed but is able to express her feelings clearly.

Impression:	Depression	HTN
	Adjustment reaction	Hyperlipidemia
	hisomnia	

Plan: Suggested that she takes Lexapro 5mg qd and decrease Valium to 5mg qhs prn insomnia. Continue other meds unchanged. **RTC 1mo for interval assessment.** If she is still having intolerable side effects from these meds, then we will change them to different ones. Precautions given for calling/returning w/ positive feedback. Further evaluation / treatment as indicated. Nature of the presenting problem: Moderate severity if not treated.

Counseling/Coordination of care: Discussion regarding impressions, prognosis, risk/benefits, treatment options, follow-up, patient education: 10-15 minutes.

Medical Decision-Making: Limited diagnoses w/ moderate amount of data to be reviewed, moderate complexity of decision making and moderate morbidity.

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7/27/06

4 - Healthcare inf...

70yo

7/06 Cholesterol 190, triglyceride 150, HDL 40, LDL 120 on Zocor 40mg qd.
Patient is still somewhat depressed about her husband's death even though it was 2 years ago. She feels that increased dose Prozac 40mg qhs has lost its effectiveness, and she would like to try a different antidepression medicine. She only c/o significant insomnia in that she cannot shut off racing thoughts when she goes to bed. This is not so much a problem with anxiety in the daytime.
Pt has multiple arthritis pains which bother her so significantly that she would like a manual wheelchair. Because of bilateral hip arthritis, she cannot even walk through a grocery store despite increased dose Diclofenac 75mg bid. Complete Review of Systems otherwise minimized.
Exam: 20 80 143/78
Patient pleasant, cooperative, talkative; sits comfortably in chair. Brief exam unchanged from previous visit.

Impression:	HTN	Hyperlipidemia
	Overweight/deconditioning	Depression/insomnia
	Multiple OA	

Plan: DC Prozac (ineffective). Start Lexapro 10mg qd. Samples & Rx provided. Other supportive measures described at length including Valium 10mg qhs for insomnia with positive feedback.
Rx for manual wheelchair (bilateral hip DJD, HTN, hyperlipidemia). **RTC 1mo for interval assessment.**
Nature of the presenting problem: Moderate severity if not treated.
Counseling/Coordination of care: Discussion regarding impressions, prognosis, risk/benefits, treatment options, follow-up, patient education: 10-15 minutes.
Medical Decision-Making: Limited diagnoses w/ moderate amount of data to be reviewed, moderate complexity of decision making and moderate morbidity.

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6/28/2006

4 - Healthcare info...

70 years old.

Patient is a pleasant 70 year-old white, Scottish female with a history of hypertension, hyperlipidemia, arthritis, and depression, who is here to establish care. She complains that she has a shortness of breath and dyspnea with exertion, but also adds that she has bilateral hip replacements is still bother her. She has had a mild sore throat, but otherwise denies other mild viral or seasonal symptoms that could be bothering her. She takes OTC antacids as needed for heartburn. She mentions some difficulty sleeping, poor energy level, and depression related to the untimely death of her husband three years ago. She took care of him while he was quite ill with Agent Orange for three years until he died in 2003. She has recently moved to this area to be close to her two sons and four grandsons, but has found the transition a bit difficult. She is been on Prozac 20 mg q.d. for two to three years, but feels like the effect has been lost. Although she does not have significant hip discomfort, she still walks with a cane only for reassurance. Patient denies any colds, coughs, flus, fevers, chills, sweats, ear pain, sore throat, and dysuria. Pt denies any runny/itchy eyes & nose with sneezing. Patient denies any chest pain, shortness of breath, palpitations, racing heart, and skipped beats. Patient denies any urinary burning, pain, hesitancy, incontinence, sexual dysfunction, frequency, urgency, nocturia, hematuria, and residual sensation. Patient denies any constipation, diarrhea, or blood in stool. Complete Review of Systems otherwise minimized.

PMH: Left hip replacement surgery 2002. Right hip replacement surgery 2004 was followed by the complication of renal failure; ever since that time, the patient has not felt "completely right."

Medications: HCTZ 25 mg q.d., Toprol 50 mg q.d., Zocor 40 mg q.d., Zestril 20 mg q.d., Prozac 20 mg q.d., diclofenac 75 mg q.d. NKDA.

Exam: 18 76 134/96 (patient refuses weight)

Well nourished, well developed, obese, white female in no acute distress; pleasant, cooperative and talkative. EOMI, PERRLA. TMs clear. Pharynx benign. Teeth in for repair with many missing and carious teeth. No cervical nodes nor JVD. Heart regular rhythm with no murmur. Lungs CTAT. Abdomen soft, flat, nontender to palpation with no HSM nor masses; BS+. Extremities FROM with strong symmetrical pulses throughout; no CCE.

Impression:	Hypertension	Hyperlipidemia
	Overweight/Deconditioning	Depression/Bereavement
	Multiple Arthritis	Adjustment Reaction

Plan: Increase Prozac to 40 mg q.h.s. She says this medication is somewhat sedating for her, and so we will use that side effect to her advantage to improve her sleep. Will also increase the dose in an attempt to recover some of her depression symptoms. If this is unsuccessful, then we will try different medicine altogether.

Increase diclofenac to 75 mg b.i.d. for maximum anti-arthritis effect. Other medications refilled unchanged.

Completed a handicapped application sticker for her.

Sent her for fasting lipid profile to check on Zocor effectiveness. Precautions given for calling/returning with positive feedback. Further evaluation and treatment as indicated. RTC one month for interval assessment. Will pursue other health maintenance/patient education issues at the next visit.

Nature of the presenting problem: Moderate severity if not treated.

Counseling/coordination of care: Discussion regarding impressions, prognosis, risk/benefits, treatment options, follow-up, patient education: 10-15 minutes.

Medical Decision-making: Limited diagnoses with moderate amount of data to be reviewed; moderate complexity of decision-making and moderate morbidity.

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W. Kirk Harris, M.D.

6981 Littlerock Rd. S.W., Suite 101

FAX (360) 528-4643 Tumwater, WA 98512 (360) 943-3633

Name 4 - Healthcare inform... Date 4/30/11

Address

Rx Hold Vicodin (inadequate pain relief) #

sig Refill

Rx Start Percocet 5mg/325mg #40 sig 1 po tid #

sig can advance knee DJD prn NSF (forty) (XL) Refill

Rx #

sig Refill

DEA #BH2017829

M.D. M.D.

Substitution Permitted Dispense as Written

W. Kirk Harris, M.D.

6981 Littlerock Rd. S.W., Suite 101

FAX (360) 528-4643 Tumwater, WA 98512 (360) 943-3633

Name 4 - Healthcare informati... Date 3/16/11

Address

Rx Oxicarys 0.5mg #20 #60

sig 1 po bid Refill

Rx #

sig Refill

Rx #

sig Refill

DEA #BH2017829

M.D. M.D.

Substitution Permitted Dispense as Written

W. Kirk Harris, M.D.

6981 Littlerock Rd. S.W., Suite 101

FAX (360) 528-4643 Tumwater, WA 98512 (360) 943-3633

Name 4 - Healthcare informatio... Date 3/1/11

Address

Rx	K-Dur 10meq	#	#60
sig	sig 1 po bid	Refill	REx2
Rx		#	
sig		Refill	

DEA #BH2017829

Harris, MD

Product Selection Permitted

Dispense as Written

FAXED 3-3-11 JG

W. Kirk Harris, M.D.

6981 Littlerock Rd. S.W., Suite 101

FAX (360) 528-4643 Tumwater, WA 98512 (360) 943-3633

Name 4 - Healthcare informati... Date 2/28/11

Address

Rx	Double Allopurinol 100mg	#	#120
sig	sig 2 po bid for gout	Refill	Rx2
Rx	Lobrisone cream	#	15gm
sig	apply to breast tissue bid prn	Refill	RF:1
Rx		#	
sig		Refill	

DEA #BH2017829

[signature] M.D.

Substitution Permitted

M.D.

Dispense as Written

W. Kirk Harris, M.D.

6981 Littlerock Rd. S.W., Suite 101

FAX (360) 528-4643 Tumwater, WA 98512 (360) 943-3633

Name 4 - Healthcare information rea... Date 1/26/11

Address

Rx Start Allopurinol 100mg #30
sig 1 po qdaily for gout in Eliot/Joe Refill

Rx tylenol 500mg up to 4 times a day #
sig for pain Refill

Rx #
sig Refill

DEA #BH2017829

M.D. M.D.

Substitution Permitted Dispense as Written

W. Kirk Harris, M.D.

6981 Littlerock Rd. S.W., Suite 101

FAX (360) 528-4643 Tumwater, WA 98512 (360) 943-3633

Name 4 - Healthcare informatio... Date 1/20/11

Address

Rx Dalmane 15mg #30 sig 1 po qhs for insomnia RFx1
sig Refill

Rx #
sig Refill

Rx Slow #
sig DNST Refill

DEA #BH2017829

Harris MD

Product Selection Permitted Dispense as Written

FAXED 1/20/11 SB

W. Kirk Harris, M.D.

6981 Littlerock Rd. S.W., Suite 101
FAX (360) 528-4643 Tumwater, WA 98512 (360) 943-3633

Name [redacted] Date 1/6/11

Address

Rx Start K-Dur 10meq # #90
sig sig 1 po qd (with Lasix) Refill RPxly

Rx #
sig Refill

Rx #
sig Refill

DEA #BH2017829

FAXED 1/6/11

Harris MD

Product Selection Permitted Dispense as Written

1/6/11 pt notified R. Tumsma

W. Kirk Harris, M.D.

6981 Littlerock Rd. S.W., Suite 101
FAX (360) 528-4643 Tumwater, WA 98512 (360) 943-3633

Name [redacted] Date 1/5/11

Address

Rx Simvastatin 20mg # #90
sig sig 1 po qd Refill RPx3

Rx Lasix 40mg # #30
sig sig 1 po q am Refill RPx3

Rx #
sig Refill

DEA #BH2017829

FAXED 1/5/11

Harris MD M.D. M.D.
Substitution Permitted Dispense as Written

URGENT CARE SOUTH

6981 Littlerock Rd. S.W., Suite 101

FAX (360) 528-4643 Tumwater, WA 98512 (360) 943-3633

Name 4 - Healthcare informati... Date 10/20/10

Address

Rx DC Lexapro (feels "funny") #

sig Refill

Rx Restart Prozac 40mg #30

sig sig 1 po qd Refill prn

Rx #

sig Refill

W. Kirk Harris, M.D.
DEA #BH2017829

10-20-10
WKH

William Millar, PA-C
DEA #MM0088395

Product Selection Permitted

Dispense as Written

W. Kirk Harris, M.D.

6981 Littlerock Rd. S.W., Suite 101

FAX (360) 528-4643 Tumwater, WA 98512 (360) 943-3633

Name 4 - Healthcare informa... Date 10/4/10

Address

Rx DC Prozac (last effect) #

sig Refill

Rx #

sig Start Lexapro 10mg #30 sig 1 po qd (samples first) Refill Rx2

Rx Start Ativan 0.5mg #30 sig ½-1 po q6h prn anxiety/panic Rx1

sig Refill

DEA #BH2017829

WKH M.D.

Substitution Permitted

M.D.

Dispense as Written

W. Kirk Harris, M.D.

6981 Littlerock Rd. S.W., Suite 101

FAX (360) 528-4643 Tumwater, WA 98512 (360) 943-3633

Name 4 - Healthcare informat... Date 9/20/10

Address

Rx Hold lisinopril for now. # Refill

sig Come to the office for exam at bedtime. Refill

Rx # Refill

sig Refill

Rx # Refill

sig Refill

DEA #BH2017829

Product Selection Permitted

Dispense as Written

URGENT CARE SOUTH

6981 Littlerock Rd. S.W., Suite 101

FAX (360) 528-4643 Tumwater, WA 98512 (360) 943-3633

Name 4 - Healthcare information r... Date 9/22/10

Address

Rx UTI diagnosed! # Refill

sig Refill

Rx Start Bactrim DS # #20

sig sig 1 po bid for UTI Refill NRF

Rx # Refill

sig Refill

W. Kirk Harris, M.D.
DEA #BH2017829

William Millar, PA-C
DEA #MM0088395

Product Selection Permitted

Dispense as Written

URGENT CARE SOUTH

6981 Littlerock Rd. S.W., Suite 101

FAX (360) 528-4643 Tumwater, WA 98512 (360) 943-3633

Name 4 - Healthcare information... Date 9/9/

Address

Rx Stop Taking MENCIL, (blood pressure is too low)

sig Refill

Rx Continue Levoxin 0.25mg daily #

sig Continue HCTZ 25mg daily Refill

Rx Continue Zestril (lisinopril) 20mg daily #

sig Refill

Return in October for blood pressure diary review

W. Kirk Harris, M.D.
DEA #BH2017829

William Millar, PA-C
DEA #MM0088395

Product Selection Permitted

Dispense as Written

W. Kirk Harris, M.D.

6981 Littlerock Rd. S.W., Suite 101

FAX (360) 528-4643 Tumwater, WA 98512 (360) 943-3633

Name 4 - Healthcare informa... Date 6/3/10

Address

Rx Start metformin 500mg #60

sig Take 1 po bid for newly diagnosed type 2 DM Refill

Rx #

sig Refill

Rx #

sig Refill

DEA #BH2017829

Product Selection Permitted

Dispense as Written

W. Kirk Harris, M.D.

6981 Littlerock Rd. S.W., Suite 101

FAX (360) 528-4643 Tumwater, WA 98512 (360) 943-3633

Name 4 - Healthcare informatio... Date 5/27/10

Address

Rx Augmentin 500mg # #20
sig 1 po bid for SOMTHE Refill

Rx #
sig Refill

Rx #
sig Refill

DEA #BH2017829

Product Selection Permitted Dispense as Written

W. Kirk Harris, M.D.

6981 Littlerock Rd. S.W., Suite 101

FAX (360) 528-4643 Tumwater, WA 98512 (360) 943-3633

Name 4 - Healthcare informatio... Date 5/27/10

Address

Rx Start Wellbutrin SR 150mg #30
sig 1 po bid for additional anti-depressant effect RD×2 Refill

Rx Continue all other current medications #
sig (including Prozac) unchanged Refill

Rx #
sig Refill

DEA #BH2017829

Product Selection Permitted Dispense as Written

W. Kirk Harris, M.D.

6981 Littlerock Rd. S.W., Suite 101

FAX (360) 528-4643 Tumwater, WA 98512 (360) 943-3633

Name 4 - Healthcare inform... Date 5/27/10

Address

Rx	Dalmane 15mg	#	#30
sig	sig 1 po qhs for insomnia	Refill	RFx2
Rx		#	
sig		Refill	
Rx		#	
sig		Refill	

DEA #BH2017829

FAXED 5.27.10

Product Selection Permitted

Dispense as Written

W. Kirk Harris, M.D.

6981 Littlerock Rd. S.W., Suite 101

FAX (360) 528-4643 Tumwater, WA 98512 (360) 943-3633

Name 4 - Healthcare inform... Date 3/9/10

Address

Rx DC Soma (ineffective) #

sig Refill

Rx Robaxin 750mg #60 sig 1 po bid-tid #2x1

sig for MVA neck/shoulder spasm/tightness/pain Refill

Rx #

sig Refill

DEA #BH2017829

Product Selection Permitted Dispense as Written

W. Kirk Harris, M.D.

6981 Littlerock Rd. S.W., Suite 101

FAX (360) 528-4643 Tumwater, WA 98512 (360) 943-3633

Name 4 - Healthcare informa... Date 11/12/09

Address

Rx Patient has been seen in the family practice #

sig clinic for MVA shoulder and neck strain Refill

pain which is debilitating to her.

Rx #

sig It is recommended that she have in-home Refill

care services 2 hours a day three days a

Rx week for 1-2 months while she recovers. #

sig Refill

DEA #BH2017829

...tion Permitted Dispense as Written

W. Kirk Harris, M.D.

6981 Littlerock Rd. S.W., Suite 101

FAX (360) 528-4643 Tumwater, WA 98512 (360) 943-3633

Name 4 - Healthcare informati... Date 11/12/09

Address

Rx Start SOMA 350mg #50 sig 1 po qhs-tid for neck & shoulder spasm pain RFx1 #

sig Refill

Rx #

sig Refill

Rx #

sig Refill

DEA #BH2017829

Product Selection Permitted

Dispense as Written

URGENT CARE SOUTH

6981 Littlerock Rd. S.W., Suite 101

FAX (360) 528-4643 Tumwater, WA 98512 (360) 943-3633

Name 4 - Healthcare inform... Date 10/9/09

Address

Rx Increase Prozac to 40mg #30 sig 1 po qd #

sig Lanoxin 0.25mg #90 sig 1 po qd Refill

Indocin 25mg #90 sig 1 po tid pcn RFxly

Rx Atenolol 50mg #30 sig 1 po qd #

sig Simvastatin 40mg #30 sig 1 po qd Refill

HCTZ 25mg #30 sig 1 po qd RFxly

Rx Zestril 20mg 30 sig 1 po qd #

sig Restart Prilosec 20mg #60 sig 1 po bid Refill

W. Kirk Harris, M.D.
DEA #BH2017829

William Millar, PA-C
DEA #MM0088395

Product Selection Permitted

Dispense as Written

W. Kirk Harris, M.D.

6981 Littlerock Rd. S.W., Suite 101

FAX (360) 528-4643 Tumwater, WA 98512 (360) 943-3633

Name 4 - Healthcare informa... Date 2/5/09

Address

Rx	Prozac 20mg	#	#30
sig	sig 1 po qd	Refill	RFXLY
Rx	Lanoxin 0.25mg #30 sig 1 po qd	#	
sig		Refill	RFXLY
Rx		#	
sig		Refill	

DEA #BH2017829

Product Selection Permitted

Dispense as Written

URGENT CARE SOUTH

6981 Littlerock Rd. S.W., Suite 101

FAX (360) 528-4643 Tumwater, WA 98512 (360) 943-3633

Name 4 - Healthcare inform... Date 10/23/08

Address

Rx	Indocin 25mg #90 sig 1 po tid	#	RFXLY
sig	Atenlol 50mg #30 sig 1 po qd	Refill	RFXLY
Rx	Simvastatin 40mg #30 sig 1 po qd	#	RF/XLY
sig		Refill	
Rx	HCTZ 25mg #30 sig 1 po qd	#	RFXLY
sig	Zestril 20mg #30 sig 1 po qd	Refill	RFXLY

W. Kirk Harris, M.D.
DEA #BH2017829

William Millar, PA-C
DEA #MM0088395

Product Selection Permitted

Dispense as Written

URGENT CARE SOUTH

6981 Littlerock Rd. S.W., Suite 101

FAX (360) 528-4643 Tumwater, WA 98512 (360) 943-3633

Name 4 - Healthcare informat... Date ~~6/27/08~~

Address

Rx Colchecine 0.6mg # 12
sig Tabs 1 q8h until pain relief or loose stools Refill NR

Rx # Refill
sig

Rx # Refill
sig

W. Kirk Harris, M.D.
DEA #BH2017829

William Millar, PA-C
DEA #MM0088395

Product Selection Permitted

Dispense as Written

W. Kirk Harris, M.D.

6981 Littlerock Rd. S.W., Suite 101

FAX (360) 528-4643 Tumwater, WA 98512 (360) 943-3633

Name 4 - Healthcare informati... Date 6/18/08

Address

Rx Macrobid # #20
sig 1 po bid tx UTI Refill NR

Rx # Refill
sig

Rx # Refill
sig

DEA #BH2017829

Product Selection Permitted

Dispense as Written

W. Kirk Harris, M.D.

6981 Littlerock Rd. S.W., Suite 101

FAX (360) 528-4643 Tumwater, WA 98512 (360) 943-3633

4 - Healthcare informati...

Name _____ Date 4/29/08

Address _____

Rx Start Metformin 500mg #60
sig 1 po bid RFx2
Refill _____

Rx Never
sig
Refill _____

Rx Toxic
sig 5-22-08
Refill _____

DEA #BH2017829

Product Selection Permitted

4/30/08 FAXED 5/1/08

Dispense as Written

W. Kirk Harris, M.D.

6981 Littlerock Rd. S.W., Suite 101

FAX (360) 528-4643 Tumwater, WA 98512 (360) 943-3633

4 - Healthcare infor...

Name _____ Date 4/22/08

Address _____

Rx Lisinopril 20mg #30 sig 1 po qd RFx6m
sig ~~Imitrex 25mg #9 sig 1 po bid~~ Refill ~~RFx6m~~

Rx ~~Allopurinol 100mg #30 sig 1 po qd~~ #
sig Refill

Rx Valium 10mg #30 sig 1 po qhs pm insomnia RFx6m
sig Refill

DEA #BH2017829

Product Selection Permitted

Dispense as Written

W. Kirk Harris, M.D.

6981 Littlerock Rd. S.W., Suite 101

FAX (360) 528-4643 Tumwater, WA 98512 (360) 943-3633

Name 4 - Healthcare inform... Date 4/23/08

Address

Rx The patient's son, Greg Tuitele, accompanied her on a trip to Texas 4/4/08 - 4/11/08.	#
sig	Refill
Rx	#
sig	Refill
Rx	#
sig	Refill

DEA #BH2017829

Product Selection Permitted

Dispense as Written

W. Kirk Harris, M.D.

6981 Littlerock Rd. S.W., Suite 101

FAX (360) 528-4643 Tumwater, WA 98512 (360) 943-3633

Name 4 - Healthcare informati... Date 3/31/08

Address

Rx DC Bactrim (sick to stomach)	#
sig	Refill
Rx Start macrobid #14 sig 1 po bid for UTI NKF	#
sig	Refill
Rx	#
sig	Refill

DEA #BH2017829

Product Selection Permitted

fx'd PD 2/31/08 Safeway Port Orchard

Dispense as Written

W. Kirk Harris, M.D.

6981 Littlerock Rd. S.W., Suite 101

FAX (360) 528-4643 Tumwater, WA 98512 (360) 943-3633

Name 4 - Healthcare informati... Date 3/27/08

Address

Rx	Paxil 20mg #30 sig 1 po qd	#	RF x6m
sig	HCTZ 25mg #30 sig 1 po qd	Refill	RF x6m
	Atenolol 50mg #30 sig 1 po qd		RF x6m
Rx	Zocor 40mg #30 sig 1 po qd	#	RF x6m
sig	Zestril 20mg #30 sig 1 po qd	Refill	RF x6m
	Digoxin 0.25mg #30 sig 1 po qd		RF x6m
Rx	Diclofenac 75mg #60 sig 1 po bid	#	RF x6m
sig	Ambien 10mg #30 sig 1 po qhs prn	Refill	RF x6m
	Xanax 0.5mg #30 sig 1 po qhs prn racing thoughts		RF x2

DEA #BH2017829 Simvastatin 5mg #30 sig 1 po qhs RF x2

Product Selection Permitted

Dispense as Written

W. Kirk Harris, M.D.

6981 Littlerock Rd. S.W., Suite 101

FAX (360) 528-4643 Tumwater, WA 98512 (360) 943-3633

Name 4 - Healthcare informati... Date 3/27/08

Address

Rx	Bactrim DS	#	#14
sig	sig 1 po bid for UTI	Refill	NR
Rx		#	
sig		Refill	
Rx		#	
sig		Refill	

DEA #BH2017829

Product Selection Permitted

Dispense as Written

W. Kirk Harris, M.D.

6981 Littlerock Rd. S.W., Suite 101

FAX (360) 528-4643 Tumwater, WA 98512 (360) 943-3633

Name 4 - Healthcare inform... Date 3/27/08

Address

Rx Lancets #100
sig ~~test daily for new onset Type 2 DM~~ Refill ~~RPDly~~

Rx Test strips #100
sig ~~same sig~~ Refill ~~RPDly~~

Rx #
sig Refill

DEA #BH2017829

Product Selection Permitted Dispense as Written

W. Kirk Harris, M.D.

6981 Littlerock Rd. S.W., Suite 101

FAX (360) 528-4643 Tumwater, WA 98512 (360) 943-3633

Name 4 - Healthcare information ... Date ~~11/27/07~~

Address

Rx ~~Ambien 10mg~~ #
sig ~~sig 1 po qhs~~ Refill ~~#30 RPDly~~

Rx #
sig Refill

Rx #
sig Refill

DEA #BH2017829

11/28/07

Product Selection Permitted Dispense as Written

W. Kirk Harris, M.D.

6981 Littlerock Rd. S.W., Suite 101

FAX (360) 528-4643 Tumwater, WA 98512 (360) 943-3633

Name 6 - Identity - Whistleblow... Date 11/14/07

Address

Rx	Restart Arbien CR 6.25mg	#	#30
sig	sig 1 po qhs for insomnia	Refill	RFx2
			(samples 1st)
Rx	Start Allegra 180mg	#	#30
sig	sig 1 po qd for itching	Refill	RFx2
Rx		#	
sig		Refill	

DEA #BH2017829

Product Selection Permitted

Dispense as Written

W. Kirk Harris, M.D.

6981 Littlerock Rd. S.W., Suite 101

FAX (360) 528-4643 Tumwater, WA 98512 (360) 943-3633

Name 4 - Healthcare infor... Date 10/10/07

Address

Rx	Restart Prozac 20mg #30 sig 1 po qd	#	RFx6m
sig	HCTZ 25mg #30 sig 1 po qd	Refill	RFx6m
	~~Atenolol 50mg #30 sig 1 po qd~~		RFx6m
Rx	Zocor 40mg #30 sig 1 po qd	#	RFx6m
sig	Lisinopril 20mg #30 sig 1 po qd	Refill	RFx6m
	~~Digoxin 0.25mg #30 sig 1 po qd~~		RFx6m
Rx	Diclofenac 75mg #60 sig 1po bid	#	RFx6m
sig	Prilosec gen gastritis	Refill	

DEA #BH2017829

Product Selection Permitted

Dispense as Written

W. Kirk Harris, M.D.

6981 Littlerock Rd. S.W., Suite 101

FAX (360) 528-4643 Tumwater, WA 98512 (360) 943-3633

Name 4 - Healthcare informatio... Date 5/10/07

Address

Rx HCTZ 25mg #30 sig 1 po qd #

sig Atenolol 50mg #30 sig 1 po qd Refill

Rx Zestril 20mg #30 sig 1 po qd #

sig Diclofenac 75mg #60 sig 1 po bid Refill

Rx Start tobramycin cream .3gm apply to breast hydrotango twice daily #

sig Refill

DEA #BH2017829

Product Selection Permitted

Dispense as W

W. Kirk Harris, M.D.

6981 Littlerock Rd. S.W., Suite 101

FAX (360) 528-4643 Tumwater, WA 98512 (360) 943-3633

Name 4 - Healthcare informati... Date 5/10/07

Address

Rx Patient has been seen in the family medicine #

sig clinic for multiple medical issues. Refill

Rx Have meds so that she may take care #

sig of [illegible] needs in a satisfying way. Refill

Rx #

sig Refill

DEA #BH2017829

Product Selection Permitted

Dispense as Written

W. Kirk Harris, M.D.

6981 Littlerock Rd. S.W., Suite 101

FAX (360) 528-4643 Tumwater, WA 98512 (360) 943-3633

Name 4 - Healthcare information ... Date

Address

Rx # sig Refill

Rx # sig Refill

Rx # sig Refill

DEA #BH2017829

Product Selection Permitted Dispense as Written

W. Kirk Harris, M.D.

6981 Littlerock Rd. S.W., Suite 101

FAX (360) 528-4643 Tumwater, WA 98512 (360) 943-3633

Name 4 - Healthcare informa... Date 2/13/07

Address

Rx # sig Refill

Rx # sig Refill

Rx # sig Refill

DEA #BH2017829

Product Selection Permitted Dispense as Written

W. Kirk Harris, M.D.

6981 Littlerock Rd. S.W., Suite 101

FAX (360) 528-4643 Tumwater, WA 98512 (360) 943-3633

4 - Healthcare infor...

Name _____ Date 1/5/07

Address _____

Rx _____ # _____

sig _____ Refill _____

Rx _____ # _____

sig _____ Refill _____

GOUT DIET

Rx _____ # _____

sig _____ Refill _____

DEA #BH2017829

Product Selection Permitted

Dispense as Written

W. Kirk Harris, M.D.

6981 Littlerock Rd. S.W., Suite 101

FAX (360) 528-4643 Tumwater, WA 98512 (360) 943-3633

4 - Healthcare inform...

Name _____ Date 1/05/07

Address _____

Rx _____ # _____

sig _____ Refill _____

Rx _____ # _____

sig _____ Refill _____

Rx _____ # _____

sig _____ Refill _____

DEA #BH2017829

Product Selection Permitted

Dispense as Written

W. Kirk Harris, M.D.

6981 Littlerock Rd. S.W., Suite 101

FAX (360) 528-4643 Tumwater, WA 98512 (360) 943-3633

Name 4 - Healthcare inform... Date 11/15/05

Address

Rx	[illegible] 25mg #30 sig 1 po qd	# [illegible]
sig	Atenolol 50mg #30 sig 1 po qd	Refill [illegible]
Rx	[illegible]	# [illegible]
sig	[illegible]	Refill [illegible]
Rx	Zestril 20mg #30 sig 1 po qd	# [illegible]
sig	Diclofenac 75mg #3[illegible] sig 1 po bid	Refill [illegible]
	PC Voltaren [illegible] for pain	
Rx	Lexapro 10mg #30 sig 1 po qd	# [illegible]
sig	Start Ambien CR 12.5mg #30 sig 1 po qhs	Refill [illegible]

DEA #BH2017829

[signature]

Product Selection Permitted

Dispense as Written

W. Kirk Harris, M.D.

6981 Littlerock Rd. S.W., Suite 101

FAX (360) 528-4643 Tumwater, WA 98512 (360) 943-3633

Name 4 - Healthcare inform... Date 11/15/05

Address

Rx	Lorcetin 500mg	# 120
sig	sig 1 po bid for chronic cough	Refill RF
Rx		#
sig		Refill
Rx		#
sig		Refill

DEA #BH2017829

[signature]

Product Selection Permitted

Dispense as Written

W. Kirk Harris, M.D.
6981 Littlerock Rd. S.W., Suite 101
FAX (360) 528-4643 Tumwater, WA 98512 (360) 943-3633

4 - Healthcare inform...

Name _____ Date 5/24/05

Address _____

Rx Klonopin 2mg #30 sig 1 po qd #
sig Ativan 1mg #30 sig 1 po qd Refill

Rx Ativan 2mg #30 sig 1 po qd #
sig Diclofenac 75mg #30 sig 1 po bid Refill

Rx Decrease valium to 5mg #30 sig 1 po ghs prn insomnia #
sig Lunesta 1mg #30 take 1 po qd for 2wks/#time Refill

DEA #BH2017829

Product Selection Permitted

Dispense as Written

W. Kirk Harris, M.D.
6981 Littlerock Rd. S.W., Suite 101
FAX (360) 528-4643 Tumwater, WA 98512 (360) 943-3633

4 - Healthcare inform...

Name _____ Date 7/27/05

Address _____

Rx Neural Headache #
sig Refill

Rx Hypertension #
sig Refill

Rx #
sig Refill

DEA #BH2017829

Product Selection Permitted

Dispense as Written

W. Kirk Harris, M.D.

6981 Littlerock Rd. S.W., Suite 101

FAX (360) 528-4643 Tumwater, WA 98512 (360) 943-3633

Name 4 - Healthcare informati... Date 7/27/06

Address

Rx DC Prozac (ineffective) #

sig Start xanax 1mg #30 sig 1 po qhs Refill

Rx #

sig Start Valium 10mg #30 sig 1 po qhs for insomnia Refill

Rx #

sig Refill

DEA #BH2017829

Product Selection Permitted

Dispense as Written

W. Kirk Harris, M.D.

6981 Littlerock Rd. S.W., Suite 101

FAX (360) 528-4643 Tumwater, WA 98512 (360) 943-3633

Name 4 - Healthcare informat... Date 6/28/06

Address

Rx HCTZ 25mg #30 sig 1 po qd #30x1

sig Atenolol 50mg #60 sig 1 po qd Refill 2

Zocor 40mg #30 sig 1 po qd #30x1

Rx Lisinopril 20mg #60 sig 1 po qd #60

sig Increase Lexapro 20mg #60 sig 2 po qhs Refill 2

Diclofenac 75mg #60 increase to 1 po bid #60x1

Rx #

sig Refill

DEA #BH2017829

Product Selection Permitted

Dispense as Written

FAXED 9/5/06 MJ

A caring difference you can feel

FACSIMILE TRANSMISSION

Providence Home Services
Home Oxygen Medical Equipment
1235 NE 47thAvenue, Suite 48
Portland, OR. 97213

Date: 08/31/06

Attention: KIRK HARRIS MD

Phone Number: (360) 943 - 3633

Fax Number: (360) 528 - 4643

Patient: 4 - Healthcare information readily id...

COMMENTS:

Please sign and date the following Physician's statement of Medical Necessity-CMN, then fax it back to me at the number below.

While we greatly appreciate your sending the attached prescription enabling your patient to be set up on this equipment/supplies, the patient's insurance requires the length of need in order to process your patient's claim.

3 **Total Number of Pages, Including Cover Sheet**

MARIAN CLARK	(503) 215-7031	(503) 215-8148
SENDER:	**PHONE:**	**FAX:**

****** CONFIDENTIALITY NOTE ******

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PROVIDENCE HOME SERVICES

HOME OXYGEN & MEDICAL EQUIPMENT
1235 NE 47th Ave. Suite #148
Portland, OR 97213
Phone: (503) 215-4683 Toll-Free: (800) 782-1253 Fax: (503) 215-8448

Item# 221690

PDA, BUSINESS OPERATIONS
Generic Non-Respiratory Rx, v2
010556802

PHYSICIAN'S STATEMENT OF MEDICAL NECESSITY

Initial Prescription: [X] Renewal Prescription: [ ] ID #: 0435600004 00717702

Dear Physician;

Your cooperation in completing this form will help to insure that this patient receives the full Medicare or Insurance benefits. In most cases, reimbursement is based on the physical capabilities of the patient. Incomplete information may result in a reduction or denial of claim and /or a delay in payment.

PATIENT INFORMATION:

4 - Healthcare information readily identifiable to...

DOB: 4 - Healthc...

USTOMER ID #: 559606603A

PRESCRIBED: 08/08/2006
PRI PAYER: ZRCD
COI PAYER: 715

Patient's Diagnosis: OSTEOARTHROSIS, PELVIC/THIGH ICD-9: 715.05

The following equipment is needed by above stated patient.
This prescription applies to equipment from 08/08/2006 to 02/07/2007

Proc. Code	Description	
K0001	WC WHLCHR STD 20 RA INVC	RENTAL

X-WIDE MANUAL WHEELCHAIR. DETACHABLE ARMRESTS.

ADDITIONAL MEDICAL DOCUMENTATION:

Prognosis: FMR-TO-Post

I, the undersigned, certify that the above prescribed equipment is medically necessary for this patient's well-being. In my opinion, the equipment is both reasonable and necessary in reference to accepted standards of medical practice in treatment of this patient's condition and is not prescribed as CONVENIENCE equipment.

KIRK W HARRIS MD
6931 LITTLEROCK RD SW STE 101
TUMWATER, WA 98512-7226

UPIN: E29955
(360) 943 - 3633

PHYSICIAN SIGNATURE: Harris, MD DATE: 9-5-06

MD 2011-157968-000084
HARRIS, WILLIAM MD_2011-157968 PAGE 277

Item# 222634

OLY, HME - OLYMPIA
OLY Prescription Form, v4
050623104

PROVIDENCE HOME SERVICES
HOME OXYGEN & MEDICAL EQUIPMENT
2500 Willamette Drive NE, Suite C
Lacey, WA 98516
Phone: (360) 456-1520 Toll Free: (800) 634-4992 Fax: (360) 493-7668

LAST NAME: 4 - Healthcare information readily identifiable to ... PRINT IN CAPITAL BLOCK LETTERS MI

FIRST NAME: 4 - Healthcare information readil... 4 -...

BIRTHDATE (MO/DAY/YR): 4 - Healthcare information readily identifiable to a person - RCW 42.56...

DO NOT WRITE IN THIS SPACE

PLEASE DO NOT DESTROY

CMN # ☐☐☐☐☐☐☐☐

COPY

W. Kirk Harris, M.D.
6981 Littlerock Rd. S.W., Suite 101
FAX (360) 528-4643 Tumwater, WA 98512 (360) 943-3633

Name 4 - Healthcare infor... Date 7/27/06

Address

Rx Manual wheelchair # _____
sig _____ Refill _____

Rx ~~Bilateral hip DJD~~ Hypertension # _____
sig ~~Hyperlipidemia~~ Refill _____

Rx _____ # _____
sig _____ Refill _____

DEA #BH2017829

Product Selection Permitted

Dispense as Written

COPY

PHYSICIAN SIGNATURE: [signature]

EVENT DATE (MO/DAY/YR) 08/08/2006

DISTRIBUTION: White – Record

H:\Data\Operating\Forms\EDI\PROJECT\PATIENT\HME\Olympia\OLY Prescription Form4.DOC

PROVIDENCE HOME SERVICES

HOME OXYGEN & MEDICAL EQUIPMENT
1235 NE 47th Ave. Suite #148
Portland, OR 97213
Phone: (503) 215-4565 Toll-Free: (800) 752-1253 Fax: (503) 215-8448

Items 221690

FOX, BUSINESS OPERATIONS
Generic Non-Respiratory Rx, v2
010556302

PHYSICIAN'S STATEMENT OF MEDICAL NECESSITY

Initial Prescription: [X] Renewal Prescription: [ ] ID #: 0435600004 00717702

Dear Physician:

Your cooperation in completing this form will help to insure that this patient receives the full Medicare or Insurance benefits. In most cases, reimbursement is based on the physical capabilities of the patient. Incomplete information may result in a reduction or denial of claim and /or a delay in payment.

PATIENT INFORMATION:

4 - Healthcare information readily identifiable to a...

DOB: 4 - Healthc...

PRESCRIBED: 08/08/2006
PRI PAYER: ZRCD
COI PAYER: 715

STOMER ID # 4 - Healthc... SA

Patient's Diagnosis: DJD, GENERALIZED MULTIPLE SITE ICD-9: 715.09

The following equipment is needed by above stated patient.
This prescription applies to equipment from 08/08/2006 to 02/07/2007

Proc. Code	Description	
K0001	WC WHLCHR STD 20 RA INVC	RENTAL

X-WIDE MANUAL WHEELCHAIR. DETACHABLE ARMRESTS.

FAXED

ADDITIONAL MEDICAL DOCUMENTATION:

Prognosis: FAIR TO POOR

I, the undersigned, certify that the above prescribed equipment is medically necessary for this patient's well-being. In my opinion, the equipment is both reasonable and necessary in reference to accepted standards of medical practice in treatment of this patient's condition and is not prescribed as CONVENIENCE equipment.

KIRK W HARRIS MD
5981 LITTLEROCK RD SW STE 101
TUMWATER, WA 98512-7226

UPIN: E29955
(360) 943 - 3633

PHYSICIAN SIGNATURE: Harris, MD DATE: 9-12-06

Generic Non-Respiratory Rx

MD 2011-157968-000051

HARRIS, WILLIAM MD_2011-157968 PAGE 279

TRA | Medical Imaging
ON LILLY
formerly Northwest Radiology Group

500 Lilly Road I Olympia, WA 98506 I tel [360] 413-8383 I fax [360] 413-8323

Imaging Report

DATE OF SERVICE: 04-21-11

PATIENT NAME:
4 - Healthcare information re...

REFERRING PHYSICIAN:
WILLIAM K HARRIS, MD

ACCOUNT NUMBER:
739329

6981 LITTLEROCK RD SW STE 101

DATE OF BIRTH/SEX:
4 - Healthc... /F

OLYMPIA, WA 98512-

EXAM: LEFT KNEE X-RAY SERIES

HISTORY:
75-year-old woman with left knee pain for weeks. Pain with walking.

TECHNIQUE:
Two views.

COMPARISON:
None.

FINDINGS:
No bony fracture or dislocation. There is fairly significant degenerative spurring at the patellofemoral joint with additional spurring at the medial and lateral femoral tibial compartment. There is a small joint effusion. There is spiking of the tibial spines.

On these nonweightbearing views, I don't see see any significant joint space narrowing of the femoral-tibial compartment but there is fairly significant joint space narrowing along the patellofemoral joint.

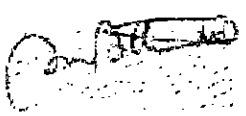
No osseous destructive lesion or periarticular calcification.

- TAKE INDOCIN FOR PAIN

IMPRESSION:
1. No acute bony abnormality.
2. Tricompartmental osteoarthritis, worse at the patellofemoral joint.
3. Small joint effusion.

→ P.T. FOR KNEE PAIN

Thank you for this referral. For consultation with the radiologist, please call 360-413-8383.



WKHpc
LMomMPC

- WANT STRONGER PAIN MEDS?

RANDALL PATTEN, MD

Oh
Ben

Littlerock Family Medi[illegible]
6981 Littlerock Rd SW Ste 101
Tumwater, WA 98512

PACLAB NETWORK LABORATORIES

CLIENT SERVICES (800) 874-2969 FAX (360) 456-2740

For additional diagnostic criteria, see our Test Directory at www.paml.com

PATIENT NAME	PATIENT ID	DOB	SEX	AGE	PT. PHONE NO.	PT.LAB NO.	
4 - Healthcare information readil...	02101936JT	4 - Healthcare inf...	F	75 Y	4 - Healthcare infor...		
PHYSICIAN	**COLLECT DATE & TIME**	**DATE OF SERVICE**	**REQUISITION NO.**	**STATUS**	**PAGE**		
HARRIS MD, KIRK	03/16/2011 15:40	03/16/2011	1000234	Final	1		

Comments/CC:W2335474:CMPAC - Patient Not Fasting; AHEMP2, ATDIF2, CMPAC- SPH

Diagnostic Procedure	In Range	Out of Range		Units	Reference Range	Site Code
Comprehensive Metabolic Panel						
Sodium	142			mmol/L	135-145	31
Potassium	3.6			mmol/L	3.5-5.3	31
Chloride		96	L	mmol/L	98-109	31
CO2		36	H	mmol/L	22-30	31
Glucose	78			mg/dL	65-99	31
Pregnant normals 65 to 94 mg/dL						
BUN	16			mg/dL	7-23	31
Creatinine		1.38	H	mg/dL	0.60-1.20	31
Calcium	9.9			mg/dL	8.5-10.5	31
Protein, Total	7.6			g/dL	6.3-8.0	31
Albumin	4.0			g/dL	3.3-4.8	31
Bilirubin, Total	1.1			mg/dL	0.1-1.5	31
Alkaline Phosphatase	71			U/L	38-110	31
AST	28			U/L	5-40	31
ALT	20			U/L	5-50	31
Hemogram with Pit						
White Blood Cells	8.4			K/uL	4.0-11.0	31
Red Blood Cells	4.64			M/uL	3.80-5.20	31
Hemoglobin	14.4			g/dL	11.6-15.5	31
Hematocrit	42.8			%	35.0-46.0	31
MCV	92.3			fL	80.0-96.0	31
MCH	31.0			pg	27.0-34.0	31
MCHC	33.6			g/dL	32.0-35.5	31
RDW	14.1			%	11.0-14.5	31
Platelets	247			K/uL	150-400	31
Differential						
Differential Type	SEE BELOW					31
Manual Diff: No						
Neutrophils	60.0			%		31
Lymphocytes	32.0			%		31
Monocytes	5.0			%		31
Eosinophils	3.0			%		31
Basophils	0.0			%		31
Nucleated RBCs	0.0			/100 WBCs		31
Neutrophils, Absolute	5.00			K/uL	2.0-7.3	31
Lymphocytes, Absolute	2.70			K/uL	1.0-3.4	31
Monocytes, Absolute	0.40			K/uL	0.0-0.8	31
Eosinophils, Absolute	0.30			K/uL	0.0-0.5	31
Basophils, Absolute	0.00			K/uL	0.0-0.1	31

Performing Labs

31 Providence St Peter Hosp, 413 Lilly Rd NE, Olympia, WA 98506

End of Report

WK Hpc B

VNB

Littlerock Family Medicine
6981 Littlerock Rd SW Ste 101
Tumwater, WA 98512

PACLAB NETWORK LABORATORIES

CLIENT SERVICES (800) 874-2969 FAX (360) 456-2740

For additional diagnostic criteria, see our Test Directory at www.paml.com

PATIENT NAME	PATIENT ID	DOB	SEX	AGE	PT. PHONE NO.	PT.LAB NO:	
4 - Healthcare information readil...	02101936JT	4 - Healthcare infor...	F	75 Y	4 - Healthcare inform...		
PHYSICIAN	**COLLECT DATE & TIME**	**DATE OF SERVICE**	**REQUISITION NO.**	**STATUS**	**PAGE**		
HARRIS MD, KIRK	02/28/2011 12:04	02/28/2011	1000162	Final	1		

Comments/CC:M2234407:CMPAC - Patient Not Fasting; CMPAC- SPH

Diagnostic Procedure	In Range	Out of Range		Units	Reference Range	Site Code
Comprehensive Metabolic Panel						
Sodium	145			mmol/L	135-145	31
Potassium		3.0	L	mmol/L	3.5-5.3	31
Chloride		96	L	mmol/L	98-109	31
CO2		38	H	mmol/L	22-30	31
Glucose	81			mg/dL	65-99	31
Pregnant normals 65 to 94 mg/dL						
BUN	18			mg/dL	7-23	31
Creatinine		1.31	H	mg/dL	0.60-1.20	31
Calcium	9.5			mg/dL	8.5-10.5	31
Protein, Total	7.1			g/dL	6.3-8.0	31
Albumin	3.7			g/dL	3.3-4.8	31
Bilirubin, Total	0.9			mg/dL	0.1-1.5	31
Alkaline Phosphatase	66			U/L	38-110	31
AST	25			U/L	5-40	31
ALT	17			U/L	5-50	31

Performing Labs

31 Providence St Peter Hosp, 413 Lilly Rd NE, Olympia, WA 98506

End of Report

She should increase her potassium dose. She is taking K-Dur 10meq once daily.

Please have her increase this to K-Dur 10meq twice daily, and we'll recheck her lab in 1 month. Thanks!

WKHPC Lmontre 3/3/11

Lmontre 3/3/11

Pt. notified Ly

Littlerock Family Medicine
6981 Littlerock Rd SW Ste 101
Tumwater, WA 98512

PACLAB NETWORK LABORATORIES

CLIENT SERVICES (800) 874-2969 FAX (360) 456-2740
For additional diagnostic criteria, see our Test Directory at www.paml.com

PATIENT NAME	PATIENT ID	DOB	SEX	AGE	PT. PHONE NO.	PT.LAB NO.	
4 - Healthcare information readil...	02101938JT	4 - Healthcare info...	F	72 Y	4 - Healthcare informati...		
PHYSICIAN	**COLLECT DATE & TIME**	**DATE OF SERVICE**			**REQUISITION NO.**	**STATUS**	**PAGE**
HARRIS MD, KIRK	01/05/2011 14:22	01/05/2011			1000016	Final	1

Comments/CC:W2171197:CMPAC - Patient Not Fasting; CMPAC- Sample received unspun, may compromise results.; AHEMP2, ATDIF2, CMPAC- SPH

Diagnostic Procedure	In Range	Out of Range		Units	Reference Range	Site Code
Comprehensive Metabolic Panel						
Sodium	141			mmol/L	135-145	31
Potassium		3.3	L	mmol/L	3.5-5.3	31
Chloride		93	L	mmol/L	98-109	31
CO2		37	H	mmol/L	22-30	31
Glucose		130	H	mg/dL	65-99	31
Pregnant normals 65 to 94 mg/dL						
BUN	20			mg/dL	7-23	31
Creatinine		1.21	H	mg/dL	0.60-1.20	31
Calcium	8.7			mg/dL	8.5-10.5	31
Protein, Total	7.2			g/dL	6.3-8.0	31
Albumin	3.8			g/dL	3.3-4.8	31
Bilirubin, Total	1.2			mg/dL	0.1-1.5	31
Alkaline Phosphatase	66			U/L	38-110	31
AST	27			U/L	5-40	31
ALT	21			U/L	5-50	31
Hemogram with Plt						
White Blood Cells	7.6			K/uL	4.0-11.0	31
Red Blood Cells	4.22			M/uL	3.80-5.20	31
Hemoglobin	13.6			g/dL	11.6-15.5	31
Hematocrit	40.2			%	35.0-46.0	31
MCV	95.1			fL	80.0-96.0	31
MCH	32.1			pg	27.0-34.0	31
MCHC	33.8			g/dL	32.0-35.5	31
RDW	13.0			%	11.0-14.5	31
Platelets	244			K/uL	150-400	31
Differential						
Differential Type	SEE BELOW					31
Manual Diff: No						
Neutrophils	65.0			%		31
Lymphocytes	27.0			%		31
Monocytes	6.0			%		31
Eosinophils	2.0			%		31
Basophils	0.0			%		31
Nucleated RBCs	0.0			/100 WBCs		31
Neutrophils, Absolute	4.90			K/uL	2.0-7.3	31
Lymphocytes, Absolute	2.10			K/uL	1.0-3.4	31
Monocytes, Absolute	0.50			K/uL	0.0-0.8	31
Eosinophils, Absolute	0.20			K/uL	0.0-0.5	31
Basophils, Absolute	0.00			K/uL	0.0-0.1	31

WK Hpc
1/6/11 Lmomtec @1121

Performing Labs

31 Providence St Peter Hosp, 413 Lilly Rd NE, Olympia, WA 98506

End of Report

1/6/11 pt notified R. Shu SMA

Cardiology Associates
500 Lilly Rd NE Olympia, WA 98506
(360) 413-8525

TEST/PROCEDURE

ECG
BRENNAN, WILLIAM P M.D.
12/01/2010

4 - Healthcare information readily ...
143-249-508
4 - Healthcare in...

INDICATIONS:
Chest Pressure/Tightness
DM Non-Insulin Controlled
Hypertension Controlled
Hypercholesterolemia

RESTING ECG: Normal sinus rhythm. Normal ECG.

[Created: WILLIAM P BRENNAN M.D. on 12/01/2010 at 12:34 PM]
[Transcribed: JESSICA JOHNSON_MA on 12/01/2010 at 01:04 PM]
[Approved PATRICIA BORN_RN for BRENNAN, WILLIAM P M.D. on 12/28/2010 at 02:58:32 PM]
[Finalized 12/28/2010 at 02:58:32 PM]

cc
W Kirk Harris MD|6981 Littlerock Road, #101|Tumwater, WA 98512

RECEIVED
JAN - 5 2011

WKH

PROVIDENCE ST.PETER HOSPITAL
CLINICAL LABORATORY
413 LILLY RD NE
OLYMPIA, WA 98506
360-493-7320

Ordering Physician: N/A
Consulting Physician:

Referring Physician:

4 - Healthcare information rea...
DOB: 4 - Healthcare i... SEX: Female
MRN: 1079775
Admitting Physician:Quinton, Ronald R
PCP: Harris, Kirk
Attending Physicain: Quinton, Ronald R
Location:
Client ID:
Page: 1 of 4
Chart Physician: Harris, Kirk

H E M A T O L O G Y

		WBC K/uL	RBC M/uL	HGB g/dL	HCT %	MCV fL	MCH pg
	Ref. Range	[4.0-11.0]	[3.80-5.20]	[11.6-15.5]	[35.0-46.0]	[80.0-96.0]	[27.0-34.0]
11/11/10	04:50:00	13.9 H	3.40 L	11.1 L	32.2 L	94.7	32.7
11/12/10	02:30:00	20.0 H	3.05 L	10.1 L	29.0 L	95.0	33.2

		MCHC g/dL	RDW %	PLT K/uL	MPV fL
	Ref. Range	[32.0-35.5]	[11.0-14.5]	[150-400]	[7.4-10.3]
11/11/10	04:50:00	34.5	13.6	83 L	9.2
11/12/10	02:30:00	35.0	13.7	106 L	9.0

C H E M I S T R Y / T H E R A P E U T I C D R U G S

		Sodium mmol/L	Potassium mmol/L	Chloride mmol/L	Bicarbonate mmol/L	Anion Gap mmol/L	Glucose mg/dL	BUN mg/dL
	Ref. Range	[135-145]	[3.5-5.0]	[98-109]	[22-30]	[5-15]	[65-99]	[7-23]
11/11/10	04:50:00	142	4.3	113 H	23	6	99	16
11/12/10	02:30:00	138	3.6	106	24	8	111 H	19

11/11/2010 04:50:00 Glucose:
Pregnant normals 65 to 94 mg/dL

		Creatinine mg/dL	GFR estimate mL/min/1.73m2	Calcium mg/dL	Phosphorous mg/dL	Magnesium mg/dL	Albumin g/dL
	Ref. Range	[0.60-1.20]		[8.5-10.5]	[2.6-4.4]	[1.5-2.4]	[3.3-4.8]
11/11/10	04:50:00	1.24 H	42	7.5 L	1.9 L	1.6	3.3
11/12/10	02:30:00	1.35 H	38	7.4 L	3.5	1.8	3.3

11/11/2010 04:50:00 GFR estimate:
Reference Range for GFR estimate:
Persistent GFR <60 is consistent with Chronic Kidney Disease
For African American, multiply the calculated GFR by 1.21

		Alk Phos U/L	ALT U/L	Triglycerides mg/dL	NRSG Gluc Rand mg/dL	SSU Gluc Rand mg/dL
	Ref. Range	[38-110]	[5-50]	[0-149]	[65-200]	[65-200]
11/10/10	05:53:00					131
11/10/10	12:01:00				186	
11/10/10	13:05:00				179	
11/10/10	14:05:00				165	
11/10/10	14:36:00				164	
11/10/10	16:01:00				142	
11/10/10	16:58:00				134	
11/10/10	17:40:00				122	
11/10/10	19:04:00				156	
11/10/10	21:12:00				165	
11/10/10	23:33:00				143	
11/11/10	01:11:00				122	
11/11/10	04:50:00	25 L	20	127		
11/11/10	04:52:00				125	

Encounter # 1030600302
MRN: 1079775

4 - Healthcare information r...

Print Date: 11/14/2010
Print Time: 10:12 PM

4 - Healthcare information readil...

CHEMISTRY / THERAPEUTIC DRUGS

	Ref. Range	Alk Phos U/L [38-110]	ALT U/L [5-50]	Triglycerides mg/dL [0-149]	NRSG Gluc Rand mg/dL [65-200]	SSU Gluc Rand mg/dL [65-200]
11/11/10	05:39:00				106	
11/11/10	06:51:00				97	
11/11/10	08:31:00				96	
11/11/10	10:14:00				140	
11/11/10	12:27:00				123	
11/11/10	14:34:00				103	
11/11/10	15:12:00				127	
11/11/10	16:56:00				159	
11/11/10	I8:02:00				169	
11/11/10	19:02:00				142	
11/11/10	20:31:00				94	
11/11/10	22:31:00				95	
11/12/10	00:17:00				90	
11/12/10	02:30:00	31 L	16	140		
11/12/10	02:45:00				135	
11/12/10	05:00:00				143	
11/12/10	06:42:00				121	
11/12/10	09:04:00				117	
11/12/10	11:06:00				84	
11/12/10	12:31:00				115	
11/12/10	13:56:00				166	
11/12/10	17:04:00				97	
11/12/10	19:04:00				135	
11/12/10	21:13:00				100	
11/12/10	23:08:00				100	
11/13/10	06:21:00				144	
11/13/10	09:31:00				123	
11/13/10	11:53:00				121	

BLOOD GASSES

Date	11/10/10	11/10/10	11/10/10	11/10/10	11/10/10	11/10/10		
Time	08:16:00	08:34:00	08:37:00	08:59:00	09:18:00	09:38:00		
							Ref. Range	
POC pH Art	7.44 H		7.41	7.33 L	7.33 L	7.32 L	[7.38-7.42]	
POC pCO2 Art	41		44 H	53 H	54 H	55 H	[31-43]	mmHg
POC pO2 Art	555 H		378 H	338 H	348 H	355 H	[80-95]	mmHg
POC BE	3.0 H		2.5 H	1.2	1.5	1.4	[-2.4-2.3]	mmol/L
POC Oxyhgb Art	98.6 H		98.4 H	98.3 H	98.5 H	98.7 H	[94.0-97.0]	%
POC pH Ven		7.36					[7.35-7.45]	
POC pCO2 Ven		51 H					[35-40]	mmHg
POC pO2 Ven		39						mmHg
POC BE Ven		2.5						
POC Oxyhgb Ven		73.6 H					[40.0-70.0]	%
POC Sodium	143	140	135	140	140	141	[135-145]	mmol/L
POC Potassium	2.8 C	4.4	5.9 H	3.8	4.0	4.2	[3.5-5.0]	mmol/L
POC Chloride	103	102	102	103	104	105	[98-109]	mmol/L
POC Anion Gap	15	14	12	13	12	13	[5-15]	mmol/L
POC Ca Ionized	1.11 L	1.23	1.21	1.16	1.17	1.18	[1.16-1.38]	mmol/L
POC Glucose	162	126	191	143	144	142	[65-200]	mg/dL
POC HCT	41.0	34.0 L	32.0 L	32.0 L	33.0 L	34.0 L	[35.0-46.0]	%
POC HGB	14.1	11.4 L	10.8 L	11.0 L	11.2 L	11.5 L	[11.6-15.5]	g/dL

4 - Healthcare information r...

MD 2011-157968-000001
HARRIS, WILLIAM MD_2011-157968 PAGE 286

4 - Healthcare information re...

B L O O D G A S S E S

	Date	11/10/10	11/10/10	11/10/10	11/10/10	11/10/10	11/10/10		
	Time	09:58:00	10:17:00	10:46:00	12:09:00	14:44:00	17:54:00		
								Ref. Range	
POC pH Art		7.39	7.39	7.44 H				[7.38-7.42]	
POC pCO2 Art		45 H	43	35				[31-43]	mmHg
POC pO2 Art		346 H	338 H	569 H				[80-95]	mmHg
POC ph(t)					7.30 L	7.24 C	7.24 C	[7.38-7.42]	
POC pCO2(t)					45 H	54 H	52 H	[31-43]	mmHg
POC pO2(t)					204 H	181 H	211 H	[80-90]	mmHg
POC BE		1.3	0.2	-1.3	-4.4 L	-4.6 L	-6.0 L	[-2.4-2.3]	mmol/L
POC FiO2					50.0	40.0	35.0		
POC Oxyhgb Art		98.1 H	98.4 H	98.5 H	97.0	97.1 H	97.4 H	[94.0-97.0]	%
POC Temp At:					36.6	36.6	36.6		
POC Sodium		138	138	140			142	[135-145]	mmol/L
POC Potassium		4.5	5.4 H	4.0	3.8	4.3	4.2	[3.5-5.0]	mmol/L
POC Chloride		105	106	108			112 H	[98-109]	mmol/L
POC Anion Gap		12	12	13			13	[5-15]	mmol/L
POC Ca Ionized		1.09 L	1.09 L	1.06 L	1.10 L	1.06 L	1.06 L	[1.16-1.38]	mmol/L
POC Glucose		186	186	150		153	115	[65-200]	mg/dL
POC HCT		33.0 L	32.0 L	31.0 L	42.0	41.0	38.0	[35.0-46.0]	%
POC HGB		11.2 L	10.9 L	10.4 L	14.2	13.9	12.8	[11.6-15.5]	g/dL

	Date	11/11/10		
	Time	01:30:00		
			Ref. Range	
POC ph(t)		7.36 L	[7.38-7.42]	
POC pCO2(t)		41	[31-43]	mmHg
POC pO2(t)		106 H	[80-90]	mmHg
POC BE		-2.4	[-2.4-2.3]	mmol/L
POC FiO2		28.0		
POC Oxyhgb Art		96.7	[94.0-97.0]	%
POC Temp At:		36.0		
POC Sodium		143	[135-145]	mmol/L
POC Potassium		4.7	[3.5-5.0]	mmol/L
POC Chloride		112 H	[98-109]	mmol/L
POC Anion Gap		13	[5-15]	mmol/L
POC Ca Ionized		1.04 L	[1.16-1.38]	mmol/L
POC Glucose		115	[65-200]	mg/dL
POC HCT		36.0	[35.0-46.0]	%
POC HGB		12.1	[11.6-15.5]	g/dL

S E R O L O G Y / M I S C E L L A N E O U S
M I C R O B I O L O G Y

	Date	11/10/10	
	Time	12:30:00	
			Ref. Range
MRSA		Negative	
MRSA by PCR.		Performed	

4 - Healthcare information ...

MD 2011-157968-000052
HARRIS, WILLIAM MD_2011-157968 PAGE 287

Providence St. Peter Hospital
Olympia, Washington

Clinical Data: POST CABG

Diagnostic Imaging

CHEST 1V PORTABLE

DATE OF EXAM: 11/11/2010

INDICATION: POST CABG

VIEWS: One-view portable chest

COMPARISON: 11/04/2010

FINDINGS: There are mediastinal drains present. Right internal jugular Swan-Ganz catheter lies at the pulmonary artery outflow tract. Coronary artery bypass graft changes and median sternotomy present. Possible aortic valvular prosthetic ring present. Heart is within normal limits in size for postoperative film. Slight prominence of the upper mediastinum consistent with a small amount of postoperative blood. Old granulomatous changes within the left apex and left upper lobe lung. No evidence of pleural effusion. Degenerative changes thoracic spine.

IMPRESSION:

1. Within normal limits for postoperative film

Dictated By: Steven J. Lengle, M.D. 11/11/2010 8:50:38 AM

signed: STEVEN J. LENGLE, M.D.
SOUTH SOUND RADIOLOGISTS

SL/sl

RECEIVED
NOV 11 2010
WKH

PT.NAME: 4 - Healthcare information readily ide...
EXAM DATE: 11-Nov-10
REF PHY: RONALD R QUINTON, MD
ROOM: CC05-1
PT TYPE: IPO

XRAY#: 431663
PT#: 1030600302
EXAM#: 94A-111110
DOB: 4 - Healthcare information re...
PT AGE: 74

MR#: 1079775
ACCESSION#: 82032237
PCP: W KIRK HARRIS, MD
CC:
CC:

Providence St. Peter Hospital
Olympia, Washington

Clinical Data: aortic stenosis Diagnostic Imaging

CHEST 2V

DATE OF EXAM: 11/4/2010

INDICATION: aortic stenosis

COMPARISON: 06/26/2009 cervical spine examination, which shows the left lung apex.

FINDINGS: At least eight radiodense for size small nodules in the left upper lobe. There is every imaged on the prior examination appear unchanged. Irregular hyperdense nodular opacity the medial left apex, unchanged. These are likely calcified granulomas. Pleural thickening in the medial left apex is unchanged.

Lungs otherwise clear. Heart and mediastinum otherwise within normal limits. Right shoulder arthropathy. Degenerative spondylosis in the thoracic spine. Degenerative disease in the lower cervical spine.

IMPRESSION:

1. Findings likely indicative of the sequelae of granulomatous disease involving the left upper lobe, with calcified granulomas and pleural/parenchymal fibrosis at the left apex. Comparison with any available prior chest radiographs would be useful. 2. No identified acute cardiopulmonary process.

Dictated By: Ian D. Timms, M.D. 11/4/2010 1:14:56 PM

signed: IAN D. TIMMS, M.D.
SOUTH SOUND RADIOLOGISTS

IDT/idt

RECEIVED
NOV - 4 2010

WKH

PT.NAME: 4 - Healthcare information readily iden...
EXAM DATE: 04-Nov-10
REF PHY: RONALD R QUINTON, MD
ROOM:
PT TYPE: OPO

XRAY#: 431663
PT#: 1030600398
EXAM#: 240A-110410
DOB: 4 - Healthcare information...
PT AGE: 74

MR#: 1079775
ACCESSION#: 20137570
PCP: W KIRK HARRIS, MD
CC:
CC:

Littlerock Family Medicine
6981 Littlerock Rd SW Ste 101
Tumwater, WA 98512

CARDIOLOGY ASSOCIATES

PACLAB NETWORK LABORATORIES

CLIENT SERVICES (800) 874-2969 FAX (360) 456-2740

For additional diagnostic criteria, see our Test Directory at www.paml.com

PATIENT NAME	PATIENT ID	DOB	SEX	AGE	PT. PHONE NO.	PT.LAB NO.	
4 - Healthcare information readil...	02101936JT	4 - Healthcare infor...	F	74 Y	4 - Healthcare inform...		
PHYSICIAN	**COLLECT DATE & TIME**	**DATE OF SERVICE**			**REQUISITION NO.**	**STATUS**	**PAGE**
BRENNAN MD, WILLIAM P	10/29/2010 15:26	10/29/2010			1001600	Final	1

Comments/CC: F1824761:BMPAC - Fasting Status Not Given; BMPAC, GFR- OLY //CC: HARRIS MD, KIRK

Diagnostic Procedure	In Range	Out of Range		Units	Reference Range	Site Code
Basic Metabolic Panel						
Sodium	140			mmol/L	135-145	PO
Potassium	3.6			mmol/L	3.5-5.3	PO
Chloride		95	L	mmol/L	98-109	PO
CO2		35	H	mmol/L	22-31	PO
Glucose		133	H	mg/dL	65-99	PO
If Pregnant, Normal=65 to 94 mg/dL.						
For additional diagnostic criteria, see our Test Directory at www.paml.com						
BUN	22			mg/dL	7-23	PO
VERIFIED						
Creatinine		1.51	H	mg/dL	0.60-1.20	PO
VERIFIED						
Calcium	9.8			mg/dL	8.5-10.5	PO
Anion Gap	10			mmol/L	2-11	PO
Estimated GFR (Calc)		34	L	ml/min/1.73m2	>60	PO

Performing Labs

PO PACLAB Olympia, 500 Lilly Rd NE, Ste. 170, Olympia, WA 98506

End of Report

WKHpc
10-1-10
gc

MD 2011-157968-000290

TRA | Medical Imaging
ON LILLY
formerly Northwest Radiology Group

500 Lilly Road | Olympia, WA 98506 | tel [360] 413-8383 | fax [360] 413-8323

Imaging Report

DATE OF SERVICE: 10-29-10

PATIENT NAME:
4 - Healthcare information re...

REFERRING PHYSICIAN:
WILLIAM P BRENNAN, MD

ACCOUNT NUMBER:
739329

500 LILLY RD NE STE 130

DATE OF BIRTH/SEX:
4 - Healthc.../F

OLYMPIA, WA 98506-

TWO VIEW CHEST

HISTORY:
Precordial pain.

COMPARISON:
None.

FINDINGS:
Two views. Cardiac silhouette is normal in size. Mediastinal contours are normal. There is mild linear increased density demonstrated within the left apical lung tissue. Focal areas of calcification, oval, and round are demonstrated within the left upper lobe. This could be related to pulmonary nodules. Small pleural plaques are not completely excluded. The right hemithorax is clear. There is no focal bony abnormality. There is no pleural effusion, pneumothorax or dominant mass lesion. The trachea is midline.

IMPRESSION:
1. Linear areas of increased density demonstrated within the left upper lobe as can be seen with scarring from prior granulomatous change.

2. Multiple oval and round calcified masses within the left upper lobe and a single peripheral lesion in the left lower lobe, possibly related to old granulomatous disease or pleural plaquing. CT scan of the chest can be utilized for further evaluation.

Thank you for this referral. For consultation with the radiologist, please call 360-413-8383.

JOANNA PRESCOTT, MD

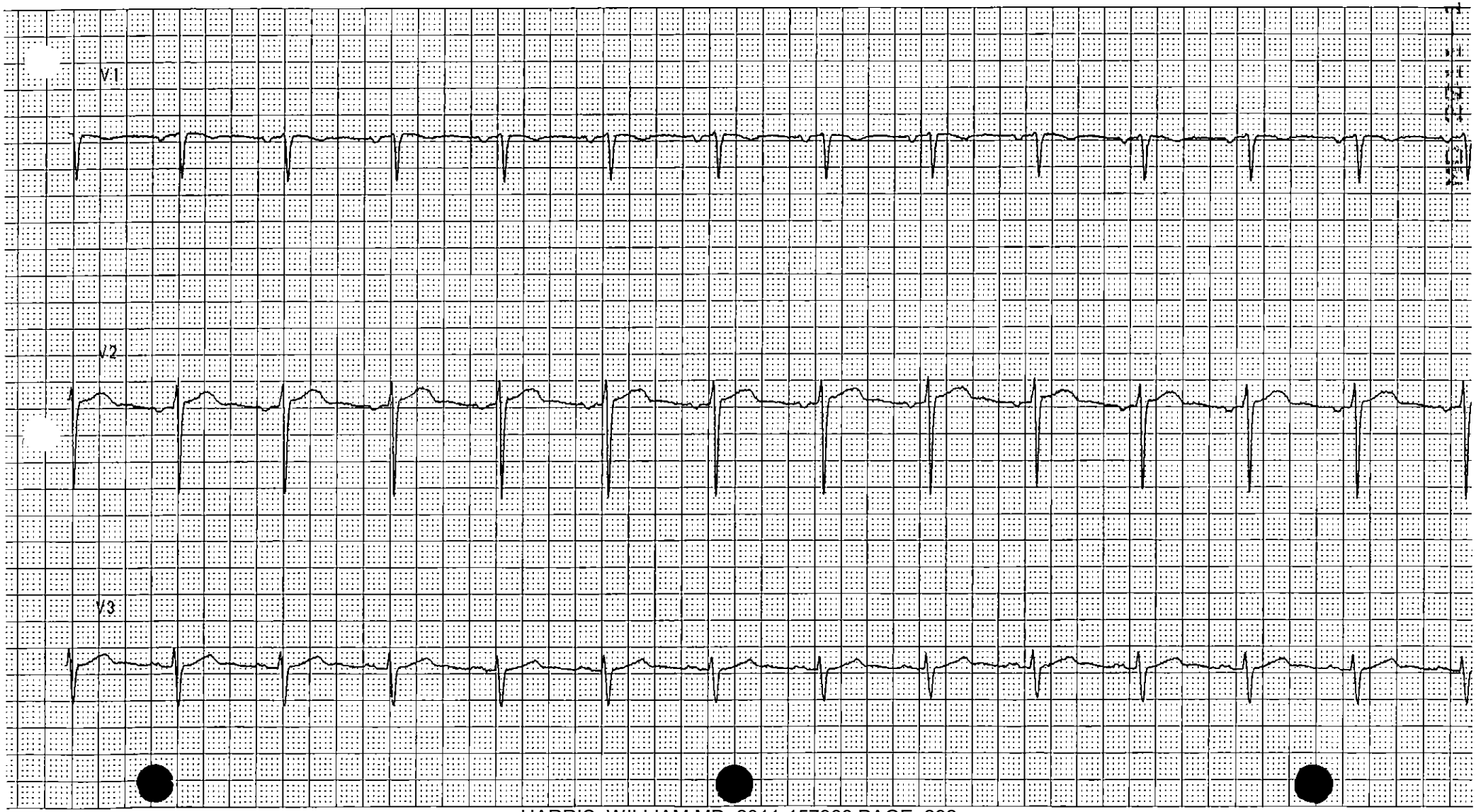
WILLIAM KIRK HARRIS, MD

10-29-10

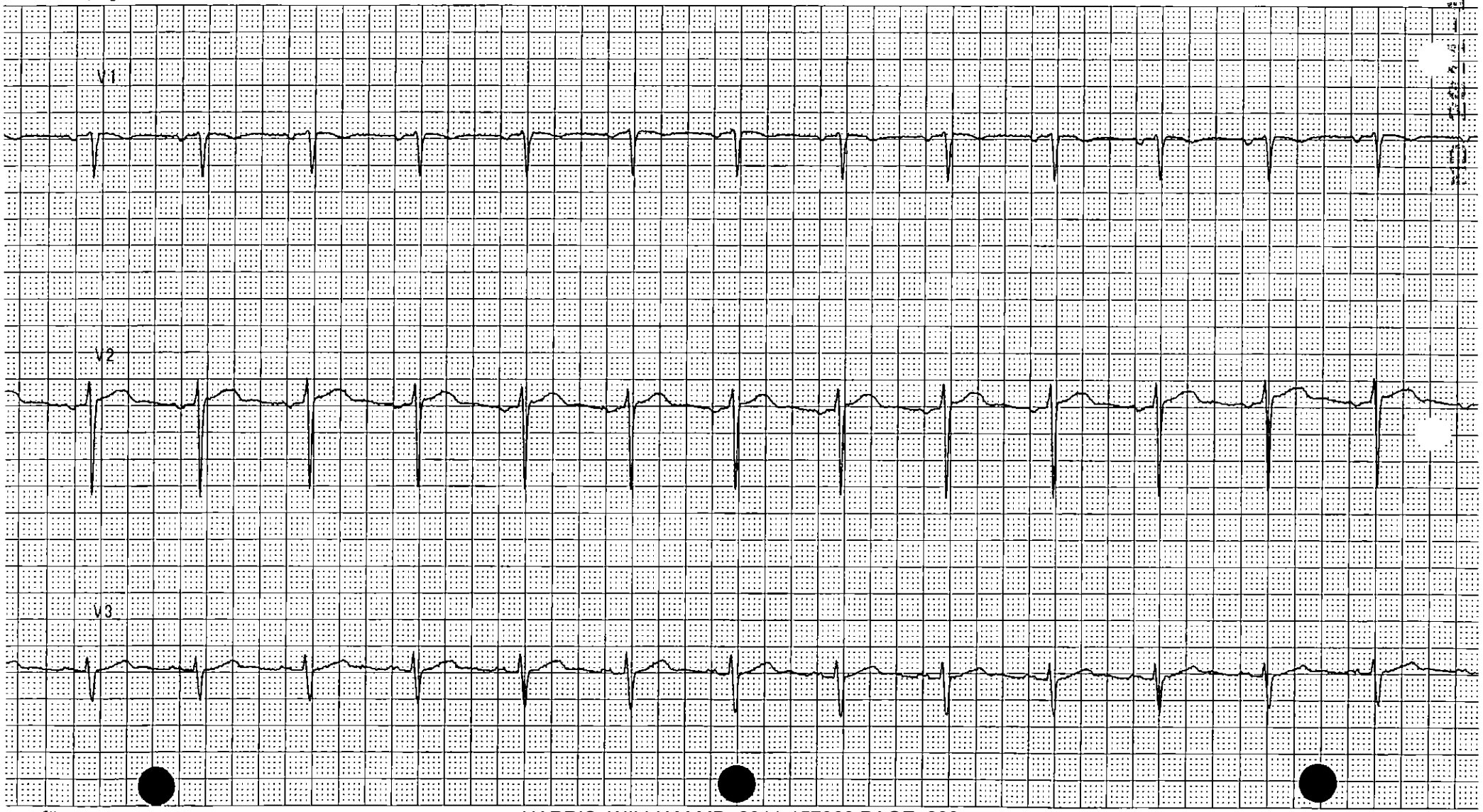
Approved By: JOANNA PRESCOTT 10-29-2010 05:12:47 PM

Name: 4 - Healthcare information re...
ID :
13:21 10/04/10
Speed: 25 mm/s ECG filter: Off
Gain : Limb 10 Chest 10 mm/mv

page 1

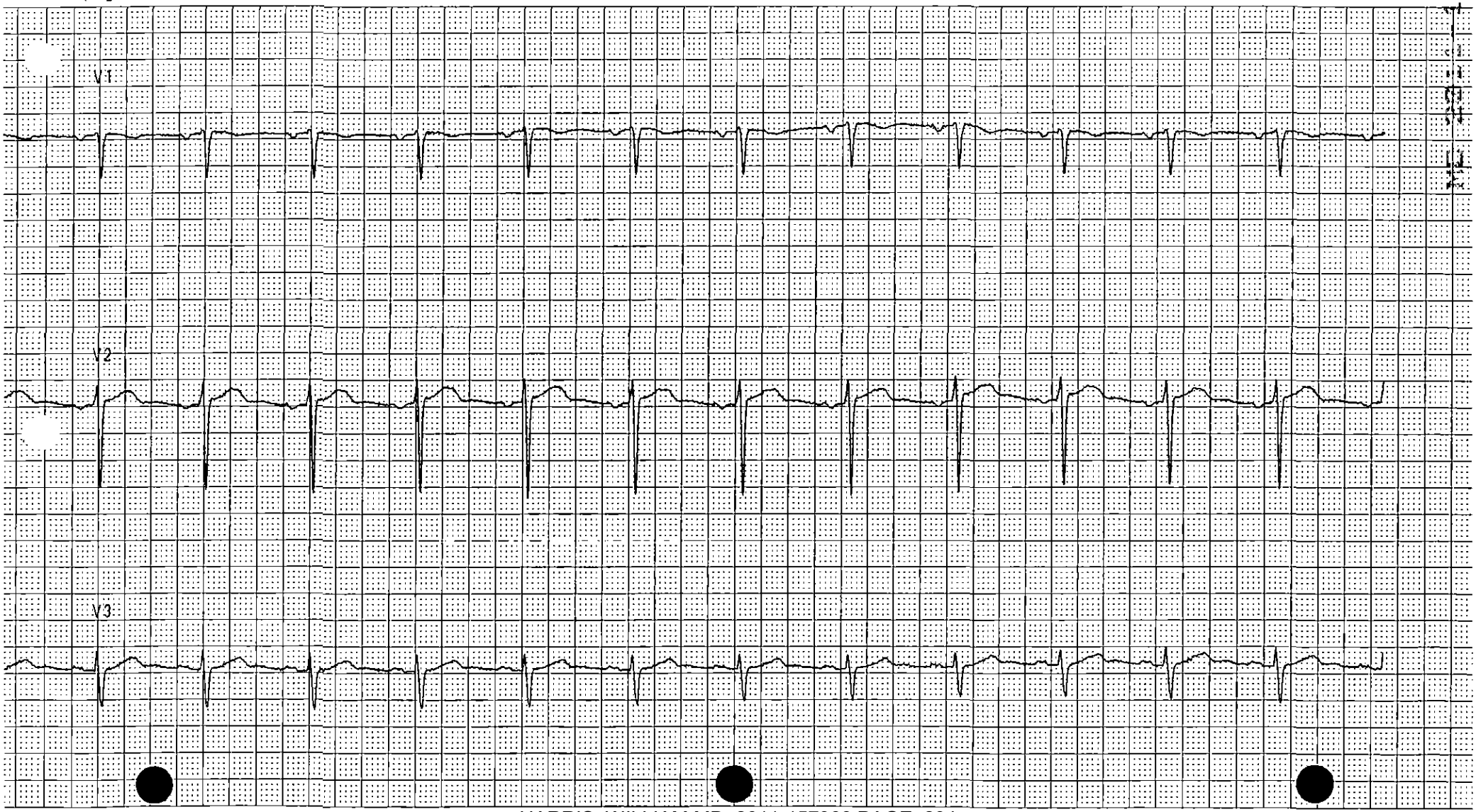


Name : 4 - Healthcare information re...
10 :
13:21 10/04/10
Speed: 25 mm/s ECG filter: Off
Gain : Limb 10 Chest 10 mm/mv



Name : 4 - Healthcare information r...
ID :
13:21 10/04/10
Speed: 25 mm/s ECG filter: Off
Gain : Limb 10 Chest 10 mm/mv

page 3



Name 4 - Healthcare information readily identifiabl...
ID

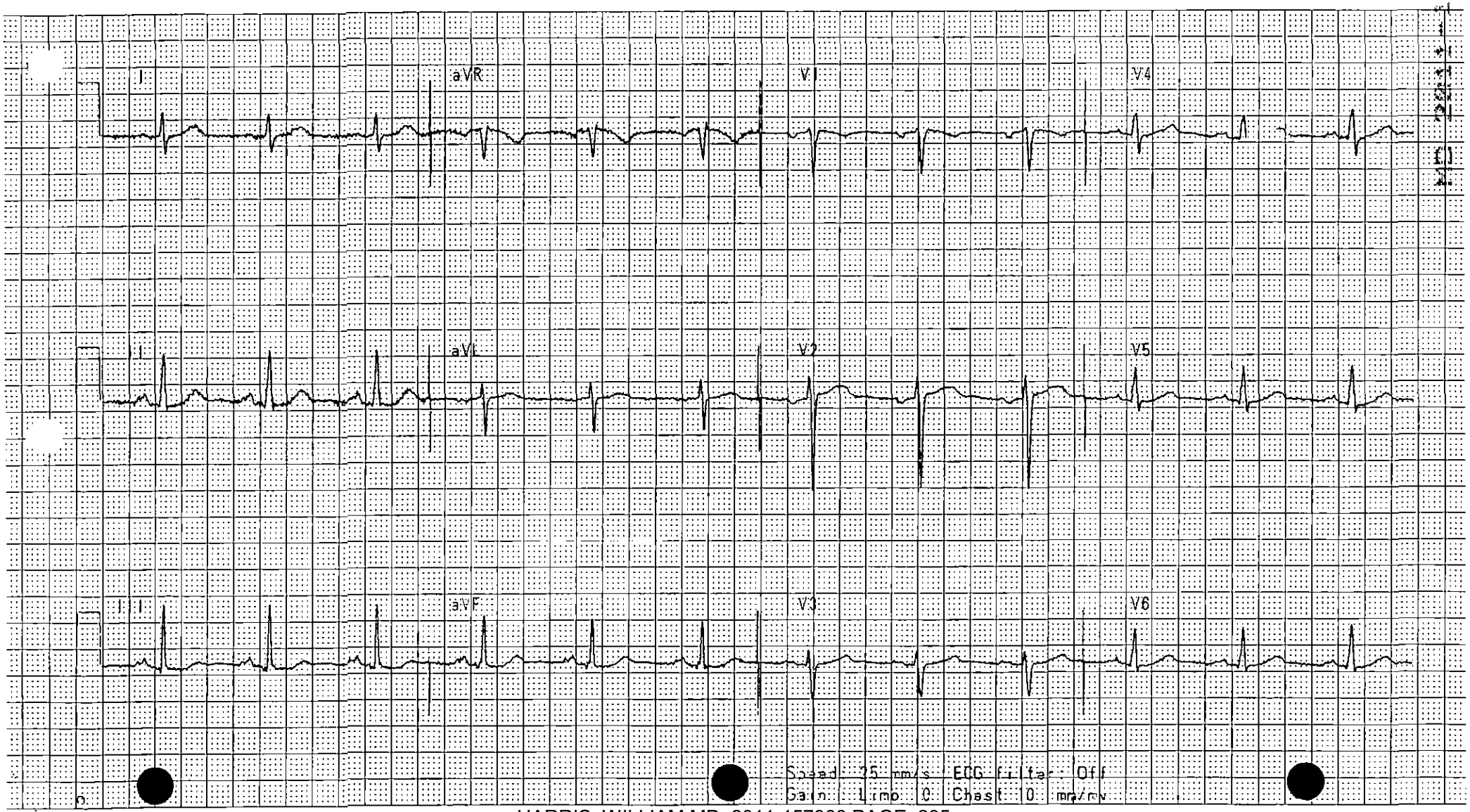
SINUS RHYTHM
NORMAL ECG

Age : 74 Sex : Female
Hgt : 53 Wgt : 195
B/P : 139/78 Race: Caucasian
Optn:
Med1: None
Med2: None
Tech: TN Dr. : HARRIS
Site: 0 Unit: 0
Date: 10/04/10 Time: 13:20

Vent	Durations			Axes		
Rate	PR	QRS	QT/QTc	P	QRS	T
72	172	88	384/409	79	79	45

WKH

57998-88613



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PATIENT NAME	PATIENT ID	DOB	SEX	AGE	PT. PHONE NO.	PT.LAB NO.	
4 - Healthcare information readil...	02101936JT	4 - Healthcare info...	F	74 Y	4 - Healthcare inform...		
PHYSICIAN	**COLLECT DATE & TIME**	**DATE OF SERVICE**	**REQUISITION NO.**			**STATUS**	**PAGE**
HARRIS MD, KIRK	09/21/2010 14:50	09/21/2010	1000710			Final	1

Comments/CC:T2003466:SPDESC , UAE, UAMC- Patient Not Fasting; AHEMP2, ATDIF2, CMPAC, GLYCO, SPDESC, TSH, UAE, UAMC- SPH

Diagnostic Procedure	In Range	Out of Range		Units	Reference Range	Site Code
Comprehensive Metabolic Panel						
Sodium	140			mmol/L	135-145	31
Potassium	3.6			mmol/L	3.5-5.3	31
Chloride	102			mmol/L	98-109	31
CO2	29			mmol/L	22-30	31
Glucose		121	H	mg/dL	65-99	31
Pregnant normals 65 to 94 mg/dL						
BUN	16			mg/dL	7-23	31
Creatinine		1.22	H	mg/dL	0.60-1.20	31
Calcium	9.4			mg/dL	8.5-10.5	31
Protein, Total	7.1			g/dL	6.3-8.0	31
Albumin	3.9			g/dL	3.3-4.8	31
Bilirubin, Total	1.2			mg/dL	0.1-1.5	31
Alkaline Phosphatase	48			U/L	38-110	31
AST	25			U/L	5-40	31
ALT	25			U/L	5-50	31
Glycohemoglobin						
Hemoglobin A1c	5.7			%	4.0-6.0	31
<7.0% Diabetic in excellent control						
Estimated Average Glucose	117			mg/dL	65-154	31
Hemogram with Plt						
White Blood Cells	8.8			K/uL	4.0-11.0	31
Red Blood Cells	4.69			M/uL	3.80-5.20	31
Hemoglobin	15.3			g/dL	11.6-15.5	31
Hematocrit	44.8			%	35.0-46.0	31
MCV	95.5			fL	80.0-96.0	31
MCH	32.7			pg	27.0-34.0	31
MCHC	34.2			g/dL	32.0-35.5	31
RDW	12.5			%	11.0-14.5	31
Platelets	178			K/uL	150-400	31
Differential						
Differential Type	SEE BELOW					31
Manual Diff: No						
Neutrophils	68.0			%		31
Lymphocytes	26.0			%		31
Monocytes	5.0			%		31
Eosinophils	2.0			%		31
Basophils	0.0			%		31
Nucleated RBCs	0.0			/100 WBCs		31
Neutrophils, Absolute	6.00			K/uL	2.0-7.3	31
Lymphocytes, Absolute	2.30			K/uL	1.0-3.4	31
Monocytes, Absolute	0.40			K/uL	0.0-0.8	31
Eosinophils, Absolute	0.20			K/uL	0.0-0.5	31
Basophils, Absolute	0.00			K/uL	0.0-0.1	31
Specimen Description	Urine					PO
Urinalysis, Routine						
Color	Yellow					31
Appearance	Cloudy					31
Glucose	Trace			mg/dL	NEG	31
Bilirubin	Negative				NEG	31
Ketones	Negative			mg/dL	NEG	31

UTI ?

Continued on next page

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PATIENT NAME	PATIENT ID	DOB	SEX	AGE	PT. PHONE NO.	PT.LAB NO.	
4 - Healthcare information readil...	02101936JT	4 - Healthcare inf...	F	74 Y	4 - Healthcare infor...		
PHYSICIAN	COLLECT DATE & TIME	DATE OF SERVICE	REQUISITION NO.			STATUS	PAGE
HARRIS MD, KIRK	09/21/2010 14:50	09/21/2010	1000710			Final	2

Comments/CC:T2003466:SPDESC , UAE, UAMC- Patient Not Fasting; AHEMP2, ATDIF2, CMPAC, GLYCO, SPDESC, TSH, UAE, UAMC- SPH

Diagnostic Procedure	In Range	Out of Range		Units	Reference Range	Site Code
Specific Gravity	1.022				1.002-1.035	31
pH	5.5				5.0-9.0	31
Protein		30	*	mg/dL	NEG	31
Urobilinogen		2.0	H	mg/dL	0.2-1.0	31
Nitrite	Negative				NEG	31
Blood	Negative				NEG	31
Leukocyte Esterase		Large	*		NEG	31
Urinalysis, Microscopic						
WBC		48	H	/hpf	0-2	31
RBC		6	H	/hpf	0-2	31
WBC Clumps	Few			/hpf		31
Bacteria	4+			/hpf		31
Squamous Epithelial Cells		21	H	/lpf	0-2	31
Mucus	Trace			/lpf		31
TSH	3.40			uIU/mL	0.40-5.00	31

Performing Labs

31 Providence St Peter Hosp, 413 Lilly Rd NE, Olympia, WA 98506

PO PACLAB Olympia, 500 Lilly Rd NE, Ste. 170, Olympia, WA 98506

End of Report

Said what ever she was taking the dr said she could stop taking, She feels better told her she needs RX and would fax it for her
10-22-10

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PATIENT NAME	PATIENT ID	DOB	SEX	AGE	PT. PHONE NO.	PT.LAB NO.	
4 - Healthcare information readil...	02101936JT	4 - Healthcare info...	F	74 Y	4 - Healthcare inform...		
PHYSICIAN	COLLECT DATE & TIME	DATE OF SERVICE			REQUISITION NO.	STATUS	PAGE
HARRIS MD, KIRK	05/27/2010 14:22	05/27/2010			1000426	Final	1

Comments/CC:H1635447:AHEMP2 , ATDIF2, CMPAC, GLYCO, TSH, UAE, UAMC- SPH

Diagnostic Procedure	In Range	Out of Range		Units	Reference Range	Site Code
Comprehensive Metabolic Panel						
Sodium	139			mmol/L	135-145	31
Potassium	4.1			mmol/L	3.5-5.3	31
Chloride	103			mmol/L	98-109	31
CO2	25			mmol/L	22-30	31
Glucose		253	H	mg/dL	65-99	31
Pregnant normals 65 to 94 mg/dL						
BUN		30	H	mg/dL	7-23	31
Creatinine		1.57	H	mg/dL	0.60-1.20	31
Calcium	9.2			mg/dL	8.5-10.5	31
Protein, Total	7.1			g/dL	6.3-8.0	31
Albumin	3.5			g/dL	3.3-4.8	31
Bilirubin, Total	1.3			mg/dL	0.1-1.5	31
Alkaline Phosphatase	62			U/L	38-110	31
AST	25			U/L	5-40	31
ALT	24			U/L	5-50	31
Glycohemoglobin						
Hemoglobin A1c		7.9	H	%	4.0-6.0	31
<7.0% Diabetic in excellent control						
Estimated Average Glucose		180	H	mg/dL	65-154	31
Hemogram with Plt						
White Blood Cells	7.0			K/uL	4.0-11.0	31
Red Blood Cells	4.38			M/uL	3.80-5.20	31
Hemoglobin	14.2			g/dL	11.6-15.5	31
Hematocrit	41.3			%	35.0-46.0	31
MCV	94.2			fL	80.0-96.0	31
MCH	32.3			pg	27.0-34.0	31
MCHC	34.3			g/dL	32.0-35.5	31
RDW	13.3			%	11.0-14.5	31
Platelets	180			K/uL	150-400	31
Differential						
Differential Type	SEE BELOW					31
Manual Diff: No						
Neutrophils	56.0			%		31
Lymphocytes	35.0			%		31
Monocytes	5.0			%		31
Eosinophils	4.0			%		31
Basophils	1.0			%		31
Nucleated RBCs	0.0			/100 WBCs		31
Neutrophils, Absolute	3.90			K/uL	2.0-7.3	31
Lymphocytes, Absolute	2.40			K/uL	1.0-3.4	31
Monocytes, Absolute	0.40			K/uL	0.0-0.8	31
Eosinophils, Absolute	0.30			K/uL	0.0-0.5	31
Basophils, Absolute	0.10			K/uL	0.0-0.1	31
Urinalysis, Routine						
Color	Yellow					31
Appearance	Hazy					31
Glucose		70	*	mg/dL	NEG	31
Bilirubin	Negative				NEG	31
Ketones	Negative			mg/dL	NEG	31
Specific Gravity	1.016				1.002-1.035	31

Continued on next page

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PATIENT NAME	PATIENT ID	DOB	SEX	AGE	PT. PHONE NO.	PT.LAB NO.	
4 - Healthcare information readil...	02101936JT	4 - Healthcare info...	F	74 Y	4 - Healthcare infor...		
PHYSICIAN	**COLLECT DATE & TIME**	**DATE OF SERVICE**	**REQUISITION NO.**	**STATUS**	**PAGE**		
HARRIS MD, KIRK	05/27/2010 14:22	05/27/2010	1000426	Final	2		

Comments/CC: H1635447:AHEMP2 , ATD1F2, CMPAC, GLYCO, TSH, UAE, UAMC- SPH

Diagnostic Procedure	In Range	Out of Range		Units	Reference Range	Site Code
pH	5.0				5.0-9.0	31
Protein	Trace			mg/dL	NEG	31
Urobilinogen	0.2 to 1.0			mg/dL	0.2-1.0	31
Nitrite	Negative				NEG	31
Blood	Negative				NEG	31
Leukocyte Esterase	Small				NEG	31
Urinalysis, Microscopic						
WBC		7	H	/hpf	0-2	31
RBC		3	H	/hpf	0-2	31
Bacteria	2+			/hpf		31
Squamous Epithelial Cells		28	H	/lpf	0-2	31
Mucus	Trace			/lpf		31
Hyaline Casts	8			/lpf		31
TSH	3.25			uIU/mL	0.40-5.00	31

Performing Labs

31 Providence St Peter Hosp, 413 Lilly Rd NE, Olympia, WA 98506

End of Report

Providence St. Peter Hospital
Olympia, Washington

Clinical Data: CAROTID STENOSIS Diagnostic Imaging

US CAROTID DUPLEX

DATE OF EXAM: 7/20/2009

INDICATION: CAROTID STENOSIS

TECHNIQUE: Real-time gray scale, color-flow, and pulsed Doppler analysis was performed of the extracranial carotid arterial systems bilaterally.

COMPARISON: None

FINDINGS: There are scattered irregular plaques with high degree of distal acoustical shadowing which involve the common and internal carotid arteries bilaterally left slightly greater than right but without elevated velocities. Velocities in the internal carotid artery plaque sites bilaterally correspond to less than 40% diameter stenosis category. Elevated velocities in the external carotid arteries of 132 cm per second on the right and 142 cm per second on the left represent moderate degree of stenosis.

Right:

	Systolic	Diastolic
ICA peak velocity (cm/sec)	75	20
CCA peak velocity (cm/sec)	88	19
ICA/CCA ratio	0.85	1.1

Antegrade flow is seen in the right vertebral artery.

Left:

	Systolic	Diastolic
ICA peak velocity (cm/sec)	68	17
CCA peak velocity (cm/sec)	72	14
ICA/CCA ratio	0.94	1.2

Antegrade a flow is seen in the left vertebral artery.

IMPRESSION:

1. Bilateral extracranial carotid plaques without hemodynamically significant degree of stenosis.
2. Antegrade flow in the vertebral arteries bilaterally.

Dictated By: Rodney Matsubara, M.D. 7/20/2009 4:40:53 PM

ADDENDUM: (21-Jul-09/13:20)
US CAROTID DUPLEX

(cont'd)

PT.NAME: 4 - Healthcare information readily ide...
EXAM DATE: 20-Jul-09
REF PHY: ROBERT LANG, MD
ROOM:
PT TYPE: DIO
XRAY#: 431663
PT#: 0920100387
EXAM#:70A-072009
DOB: 4 - Healthcare information ...
PT AGE: 73
MR#: 1079775
ACCESSION#: 18622460
PCP: W KIRK HARRIS, MD
CC:
CC:

Providence St. Peter Hospital
Olympia, Washington

nical Data: CERVICALSPINAL STENOSIS Diagnostic Imaging

SPINE/CERVICAL/5V

DATE OF EXAM: 6/26/2009

INDICATION: CERVICALSPINAL STENOSIS

VIEWS: Lateral view in neutral position, eight and with flexion and extension, AP

COMPARISON: None

FINDINGS: In neutral position there is 3-4 mm retrolisthesis of C5 on six. Alignment is, otherwise, normal. There is moderate disc space narrowing C5-C6. Mild to space narrowing present C4-C5. There is prominent osteophyte formation C5-6, moderate at C3-4 and mild at C4-5. There is also small anterior osteophyte inferior C6.

With extension, the retrolisthesis of C5 on six remains 3-4 mm. With flexion and the retrolisthesis is 2-3 mm.

IMPRESSION:

1. Retrolisthesis of C5 on C6. This reduces slightly with flexion.
2. Moderate degenerative disc disease C5-C6.
3. Spondylosis.

Dictated By: Thomas J. Luetkehans, M.D. 6/26/2009 2:57:09 PM

signed: THOMAS LUETKEHANS, M.D.
SOUTH SOUND RADIOLOGISTS

TL/tl

PT.NAME: 4 - Healthcare information readily ide...
EXAM DATE: 26-Jun-09
REF PHY: ROBERT LANG, MD
ROOM: UNK
PT TYPE: DIO

XRAY#: 431663
PT#: 0917700252
EXAM#: 2691-062609
DOB: 4 - Healthcare information r...
PT AGE: 73

MR#: 1079775
ACCESSION#: 18548936
PCP: W KIRK HARRIS, MD
CC:
CC:

Olympia Open MRI
669 Woodland Square Loop SE
Lacey, WA 98503
Phone: 360-413-9393
Fax: 360-413-9365

SOUTH SOUND RADIOLOGISTS, INC., P.S.

To: W KIRK HARRIS MD
6981 LITTLEROCK RD SW
TUMWATER, WA 98512-0000

Fax: 360-528-4643

Name: 4 - Healthcare information readily identif...
Exam Date: **5/14/09**
DOB: 4 - Healthcare informati... Gender: **Female**
MRN #: **0168468**
Referring Phys.: **W KIRK HARRIS MD**

Exam: **MRI CERVICAL SPINE WITHOUT CONTRAST** **Laterality:** **Unpaired**

CERVICAL SPINE MRI

CLINICAL HISTORY: Right arm numbness.

PROCEDURE: Axial and sagittal T1 and T2 MRI sequences of the cervical spine were performed.

COMPARISON: None.

FINDINGS: The craniocervical junction is normal. No abnormal signal appreciated within the imaged portions of the spinal cord. Multi-level degenerative disc changes are present. There is 2 mm anterolisthesis C3 on C4 and C4 on C5. No suspicious marrow signal abnormalities.

Cervical disc levels:

C2-3: Mild bilateral facet degenerative changes. No spinal canal or neuroforaminal narrowing.

C3-4: There is a moderate sized broad based disc bulge and facet degenerative change. There is a mild degree of spinal canal stenosis. Neuroforaminal narrowing is moderate-to-severe on the right and moderate on the left.

C4-5: Small circumferential disc osteophyte complex and moderate facet degenerative changes. There is effacement of the ventral aspect of the thecal sac. Neuroforaminal narrowing is mild-to-moderate on the right and moderate-to-severe on the left.

C5-6: Moderate-to-large circumferential disc osteophyte complex and bilateral facet degenerative changes. There is moderate-to-severe spinal canal stenosis with resultant deformity of the spinal cord. No cord signal abnormality appreciated. Neuroforaminal narrowing is moderate bilaterally.

C6-7: Small broad base disc bulge and facet degeneration. Slight effacement of the

WKH MD 2011-157968-000119

ventral aspect of the thecal sac. Mild bilateral neuroforaminal narrowing.

C7-T1: Normal.

IMPRESSION:
1. Multi-level degenerative disc changes and facet joint arthropathy.
2. There is moderate-to-severe central canal stenosis at the C5-6 level. Spinal canal stenosis is mild at C3-4, C4-5, and C6-7.
3. Variable degrees of neuroforaminal narrowing as described.

EXAM PERFORMED AT OLYMPIA OPEN MRI.

Interpreting Radiologist

David B. Mitchell

DAVID MITCHELL MD
Electronically Signed: 5/15/09 2:11 pm

Technologist:
Typist: JMH
Typed: 5/15/09 10:27 am

MD 2011-157968-000111

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PATIENT NAME	PATIENT ID	DOB	SEX	AGE	PT. PHONE NO.	PT.LAB NO.	
4 - Healthcare information readil...	02101936JT	4 - Healthcare info...	F	73 Y	4 - Healthcare informati...		
PHYSICIAN	**COLLECT DATE & TIME**	**DATE OF SERVICE**			**REQUISITION NO.**	**STATUS**	**PAGE**
HARRIS MD, KIRK	02/19/2009 09:40	02/19/2009			1000124	Final	1

Comments/CC: H692009:CMPAC , TSH- OLY; TSH- Patient Fasting; GLYCO- SPH

Diagnostic Procedure	In Range	Out of Range		Units	Reference Range	Site Code
Comprehensive Metabolic Panel						
Sodium	143			mmol/L	135-145	PO
Potassium	3.9			mmol/L	3.5-5.3	PO
Chloride	106			mmol/L	98-109	PO
CO2	30			mmol/L	22-31	PO
Glucose		120 ✓	H	mg/dL	65-99	PO
If Pregnant, Normal=65 to 94 mg/dL. For additional diagnostic criteria, see our Test Directory at www.paml.com						
BUN	21			mg/dL	7-23	PO
Creatinine	1.2			mg/dL	0.6-1.2	PO
Calcium	9.4			mg/dL	8.5-10.5	PO
Protein, Total	6.8			g/dL	6.1-7.8	PO
Albumin	3.3			g/dL	3.3-4.8	PO
Bilirubin, Total		1.4	H ✓	mg/dL	0.2-1.1	PO
Alkaline Phosphatase	43			U/L	38-110	PO
AST	22			U/L	5-40	PO
ALT	19			U/L	5-50	PO
Anion Gap	7			mmol/L	2-11	PO
Glycohemoglobin						
Hemoglobin A1c		6.1	H	%	4.0-6.0	31
<7.0% Diabetic in excellent control						
Est Mean Whole Bld Glucose	See Note			mg/dL		31
Mean Blood Glucose invalid for HgbA1c <6.5%.						
TSH	3.89			uIU/mL	0.40-5.00	PO

Performing Labs

31 Providence St Peter Hosp, 413 Lilly Rd NE, Olympia, WA 98506

PO PACLAB Olympia, 500 Lilly Rd NE, Ste. 170, Olympia, WA 98506

End of Report

WH

4/9/09
3/17/09 Unomore

MD 2011-157968-000112

PATIENT INFORMATION			CLIENT INFORMATION
NAME 4 - Healthcare information ...			Littlerock Family Medicine
AGE 72Y DOB 4 - Healthcare infor... SEX F			710738
LAB NO. 02101936JT			6981 Littlerock Rd SW Ste 101
PATIENT PHONE NO.: 4 - Healthcare informati...			Tumwater,WA 98512
			HARRIS MD, KIRK

PACLAB OLYMPIA
PACLAB NETWORK LABORATORIES
500 Lily Rd. NE, Suite 170
Olympia, Washington 98506
(360) 456-1900 (800) 874-2969
FAX (360) 456-2740

PT. NUMBER	REPORTED	PAGE
02101936JT	04/21/2008 08:00	1

TESTS REQUESTED:
F142371 ORDERS:AHEMP2,ATDIF2,CMPAC,GFR,GLYCO,LIPID,TSH
COL: 04/18/2008 09:43 REC: 04/18/2008 10:40

TEST NAME	RESULTS OUT OF RANGE	RESULTS IN RANGE	UNITS	REFERENCE	
ORDER COMMENT:Patient Fasting					
Comprehensive Metabolic Panel					
Sodium		138	mmol/L	135-145	[PO]
Potassium		3.9	mmol/L	3.5-5.3	[PO]
Chloride		102	mmol/L	98-109	[PO]
CO2		27	mmol/L	22-31	[PO]
Glucose	H 125		mg/dL	65-99	[PO]
If Pregnant, Normal=65 to 94 mg/dL.					
For additional diagnostic criteria, see our Test Directory at www.paml.com					
BUN	H 25		mg/dL	7-23	[PO]
Creatinine	H 1.4		mg/dL	0.6-1.2	[PO]
Calcium		9.0	mg/dL	8.5-10.5	[PO]
Protein, Total		7.5	g/dL	6.1-7.8	[PO]
Albumin		3.5	g/dL	3.3-4.8	[PO]
Bilirubin, Total	H 1.5		mg/dL	0.2-1.1	[PO]
Alkaline Phosphatase		46	U/L	38-110	[PO]
AST		30	U/L	5-40	[PO]
ALT		30	U/L	5-50	[PO]
Anion Gap		9	mmol/L	2-11	[PO]
Estimated GFR (Calc)	L 37		ml/min/	>60	[PO]
GFR <60: Chronic kidney disease, if found over a 3 month period.					
GFR <15: Kidney failure.					
For African Americans, multiply the calculated GFR by 1.210					
Glycohemoglobin					
Hemoglobin A1c	H 8.3		%	4.0-6.0	[31]
<7.0% Diabetic in excellent control					
Est Mean Whole Bld Glucose		190	mg/dL		[31]
Lipid Profile					
Cholesterol		136	mg/dL	<200	[PO]
Triglycerides		118	mg/dL	<150	[PO]
HDL	L 31		mg/dL	40-59	[PO]
For specific risk assessment criteria, see our test directory at (www.paml.com).					
LDL [Calculated]		81	mg/dL	<130	[PO]
The LDL goal varies from 70 to 160 depending on the clinical risk category. For specific risk assessment criteria, see our test directory at (www.paml.com).					

4 - Healthcare information ... CONTINUED

TERRENCE A SCHULTE, M.D., MEDICAL DIRECTOR

MD 2011-157968-000112

PATIENT INFORMATION

NAME 4 - Healthcare information ...
AGE 72Y DOB 4 - Healthcare inform... SEX F

LAB NO. 02101936JT
PATIENT PHONE NO.: 4 - Healthcare informati...

PACLAB OLYMPIA

PACLAB
NETWORK LABORATORIES
500 Lily Rd. NE, Suite 170
Olympia, Washington 98506
(360) 456-1900 (800) 874-2969
FAX (360) 456-2740

CLIENT INFORMATION

Littlerock Family Medicine
710738
6981 Littlerock Rd SW Ste 101
Tumwater,WA 98512
HARRIS MD, KIRK

PT. NUMBER	REPORTED	PAGE
02101936JT	04/21/2008 08:00	2

TESTS REQUESTED:
F142371 ORDERS:AHEMP2,ATDIF2,CMPAC,GFR,GLYCO,LIPID,TSH||
COL: 04/18/2008 09:43 REC: 04/18/2008 10:40

TEST NAME	RESULTS OUT OF RANGE	RESULTS IN RANGE	UNITS	REFERENCE	
ORDER COMMENT:Patient Fasting					
Lipid Profile (CONTINUED)					
Chol/HDL Ratio	H 4.4			<3.3	[PO]
Hemogram with Plt					
White Blood Cells		8.4	K/uL	4.0-11.0	[PO]
Red Blood Cells		4.56	M/uL	3.80-5.20	[PO]
Hemoglobin		14.9	g/dL	11.6-15.5	[PO]
Hematocrit		43.4	%	35.0-46.0	[PO]
MCV		95.1	fL	80.0-100.0	[PO]
MCH		32.5	pg	27.0-34.0	[PO]
MCHC		34.2	g/dL	32.0-35.5	[PO]
RDW		11.5	%	11.0-15.0	[PO]
Platelets		226	K/uL	150-400	[PO]
Differential					
Segs		41.0	%	38-70	[PO]
Bands		3.0	%	0-8	[PO]
Lymphocytes	H 50.0		%	15-45	[PO]
Monocytes		4.0	%	0-12	[PO]
Eosinophils		1.0	%	0-7	[PO]
Basophils		1.0	%	0-2.0	[PO]
Segs, Absolute		3.44	K/uL	1.8-7.7	[PO]
Bands, Absolute	H 0.25		K/uL	0-0.20	[PO]
Lymphocytes, Absolute	H 4.21		K/uL	1.00-3.40	[PO]
Monocytes, Absolute		0.34	K/uL	0.00-0.80	[PO]
Eosinophils, Absolute		0.08	K/uL	0.0-0.5	[PO]
Basophils, Absolute		0.08	K/uL	0.0-0.1	[PO]
Differential Type		Manual			[PO]
WBC Morphology					[PO]
No Atypical Lymphs					
TSH		4.16	uIU/mL	0.40-5.00	[PO]

[31] Providence St Peter Hosp, 413 Lilly Rd NE, Olympia, WA 98506
[PO] PACLAB Olympia, 500 Lilly Rd NE, Ste. 170, Olympia, WA 98506

4 - Healthcare information ...

END OF REPORT PAGE 2

TERRENCE A SCHULTE, M.D., MEDICAL DIRECTOR

Northwest Radiology Group, LLC

500 Lilly Road NE, Suite 160 * Olympia, WA 98506 * Phone: (360) 413-8383 Fax: (360) 413-8323

4 - Healthcare information readily ide...

HEAD CT without IV contrast
Date of exam: April 19, 2007

4 - Healthc...

Patient #: 04038592
Ticket #: 74520

CLINICAL INDICATION: 71-year-old female with dizziness and experience of seeing flashing lights.

COMPARISON STUDIES: None.

TECHNIQUE: 5 mm thick helical CT scans through the brain from skull base to vertex. 2 mm thick helical CT scans are perfonned through the region of the sella turcia. No intravenous contrast agent given because patient refused this.

FINDINGS: Ventricles, cisterns and sulci are within nonnal limits for patient's age. No midline shift, mass or mass effect. No intraparenchymal hemorrhage identified. No extraaxial fluid collection or hematoma seen.

Basal ganglia appear nonnal. Midbrain, upper cord and posterior fossa unremarkable. Region of the sella turcica suggests a partial empty sella. I do not see a suprasellar mass. Region of the cavernous sinus and circle of Willis appears grossly unremarkable.

Skull base and bony calvarium intact. Orbits, paranasal sinuses and mastoid air cells appear gross clear. Internal auditory canals do not appear expanded. I do not see a mass in the region of the region of the cerebellopontine angles.

IMPRESSION:

1. No acute intracranial abnormality identified.
2. Probable partial empty sella.
3. No finding explains patient's symptoms.

WKHpc

Randall M Patten, MD
Radiologist

REFERRING PHYSICIAN: **W Kirk Harris, MD**
Thank you for this referral. For consultation with the radiologist, please call 360-413-8383.
rm

DICTATED BUT NOT REVIEWED

FAXED 4/20/07

4-30-07

Northwest Radiology Group, LLC

500 Lilly Road NE, Suite 160 * Olympia, WA 98506 * Phone: (360) 413-8383 Fax: (360) 413-8323

4 - Healthcare information readily ident...

RIGHT KNEE X-RAY SERIES
Date of examination: 04/06/2007

4 - Healthcare i...

Patient #: 04038592
Ticket #: 73742

CLINICAL INDICATION: Ongoing right knee pain for the last five years in a 71-year-old woman. No known acute injury.

FINDINGS: Two views are supplied showing no acute fracture or dislocation. No definite joint effusion. No discrete focal osseous lesion.

There is spiking of the tibial spines with femoral tibial spurring but no obvious femoral tibial joint space narrowing on these nonweightbearing views. There is marked patellofemoral joint space narrowing and spurring and there is increased density in the region of the joint space which could represent either chondrocalcinosis or small intraarticular loose bodies. No periarticular calcifications or soft tissue mass.

Along the distal medial metaphysis of the femur, there appears to be mild cortical expansion in a somewhat bulbous appearance of the distal bone. I believe this is likely an abnormal stress reaction or normal variation. I do not see any osseous destruction or focal neoplasm. There is slight resultant valgus angulation of the knee joint.

IMPRESSION: There appears to be fairly severe degenerative changes of the knee predominantly in the patellofemoral compartment. The preference of patellofemoral joint space narrowing and spurring is a finding associated with calcium pyrophosphate crystal deposition disease (CPPD). No acute bony abnormality is shown.

Randall M. Patten, MD
Radiologist

WKHpc

REFERRING PHYSICIAN: W Kirk Harris, MD
Thank you for this referral. For consultation with the radiologist, please call 360-413-8383.
db

4/11/07

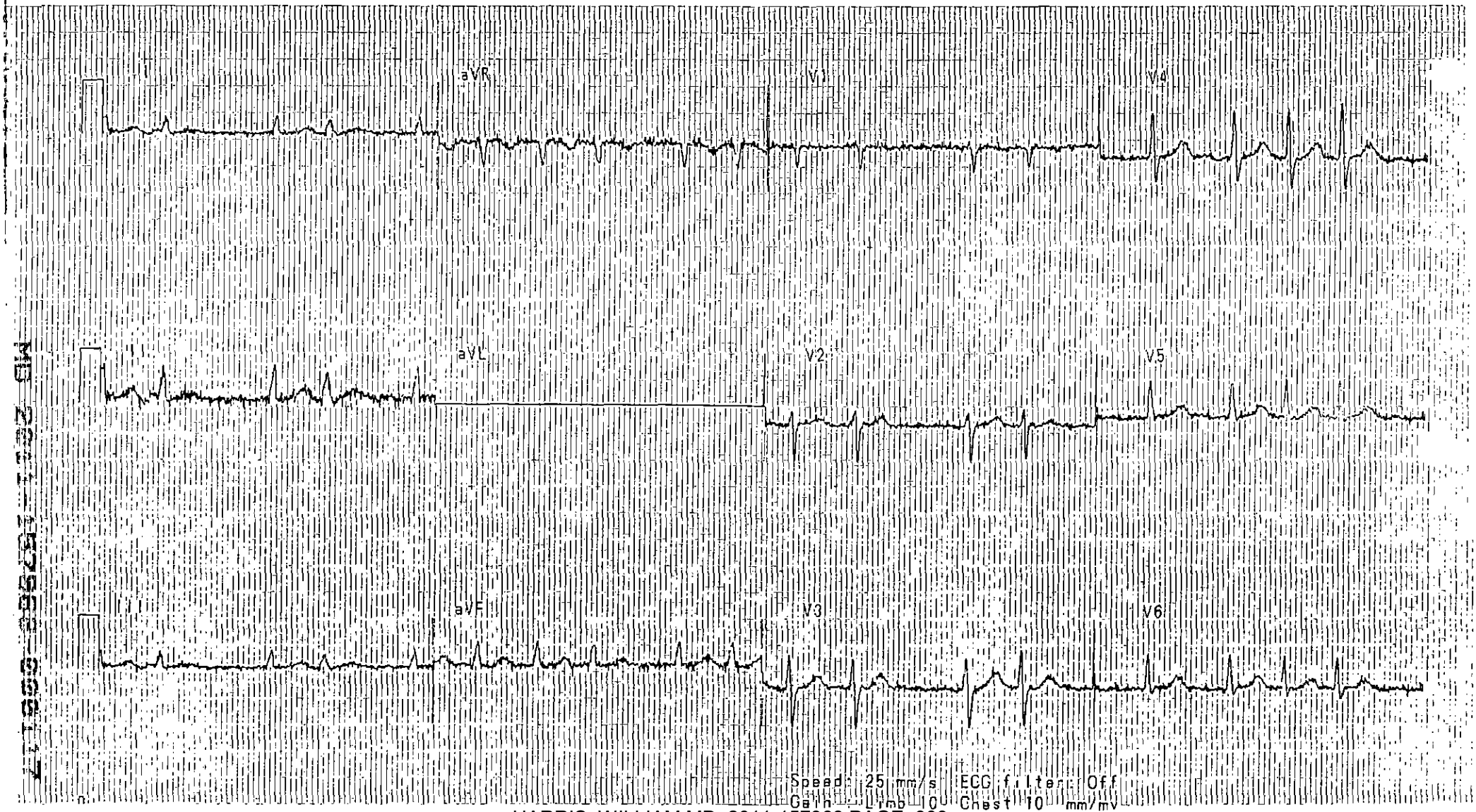
FAXED 4/9/07

4 - Healthcare information readily identifiable t...

Name : [redacted]
ID [redacted]931352
Age [redacted]70 Sex : Female
Hgt : 53 Wgt : 240
B/P : 100/84 Race: Caucasian
Dptn:
Med1: None
Med2: None
Tech: ML Dr. : HARRIS
Site: C Unit: 0
Date: 01/15/07 Time: 13:41

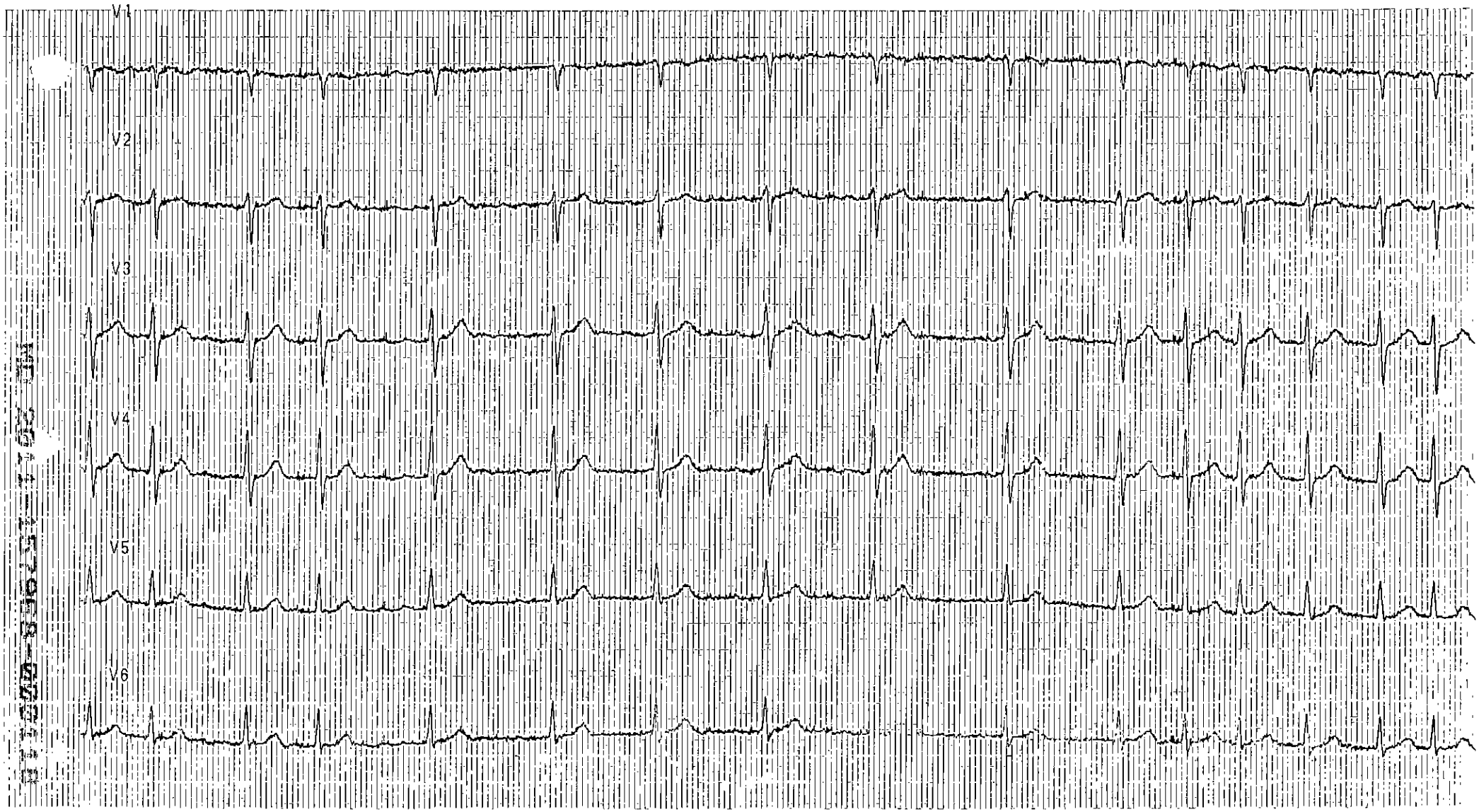
Vent Rate	Durations PR	QRS	QT/QTc	Axes P	QRS	T
107	C	96	328/391	999	55	-32

ATRIAL FIBRILLATION WITH RAPID VENTRICULAR RESPONSE WITH ABERRANT CONDUCTION OR
VENTRICULAR PREMATURE COMPLEXES
MODERATE ST DEPRESSION (0.05+ MV ST DEPPESSION), PROBABLY DIGITALIS EFFECT
ABNORMAL QRS-T ANGLE (QRS-T ANGLE GREATER 60)
ABNORMAL ECG



Name:
ID [redacted]1352
13:4[redacted]1/15/07
Speed: 25 mm/s ECG filter: Off
Gain : Limb 10 Chest 10 mm/mv

page 1

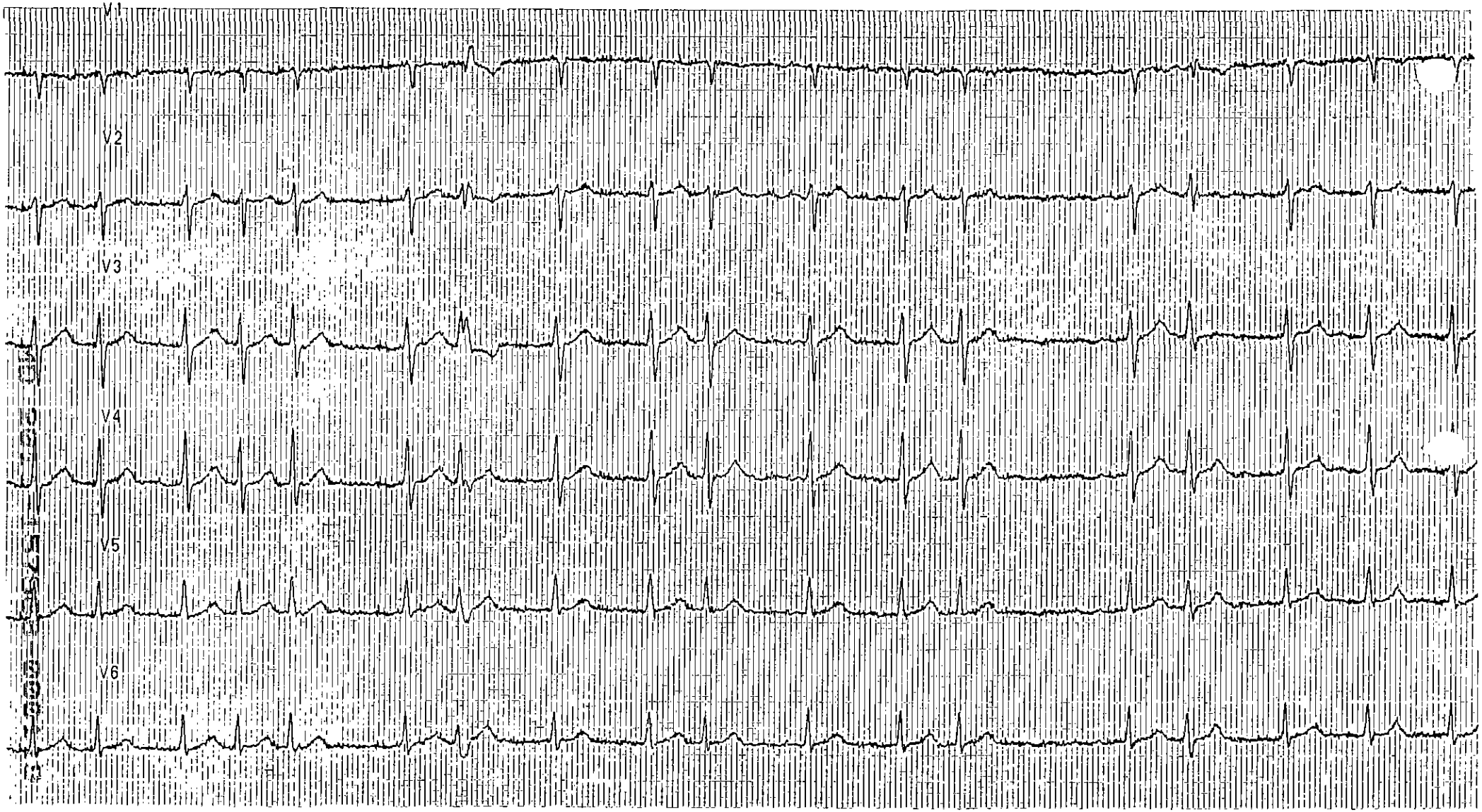


1-8505 .

MADE IN USA

Name: 4 - Healthcare information r...
ID : [redacted]1352
13:40 [redacted]/15/07
Speed: 25 mm/s ECG filter: Off
Gain : Limb 10 Chest 10 mm/mv

page 2

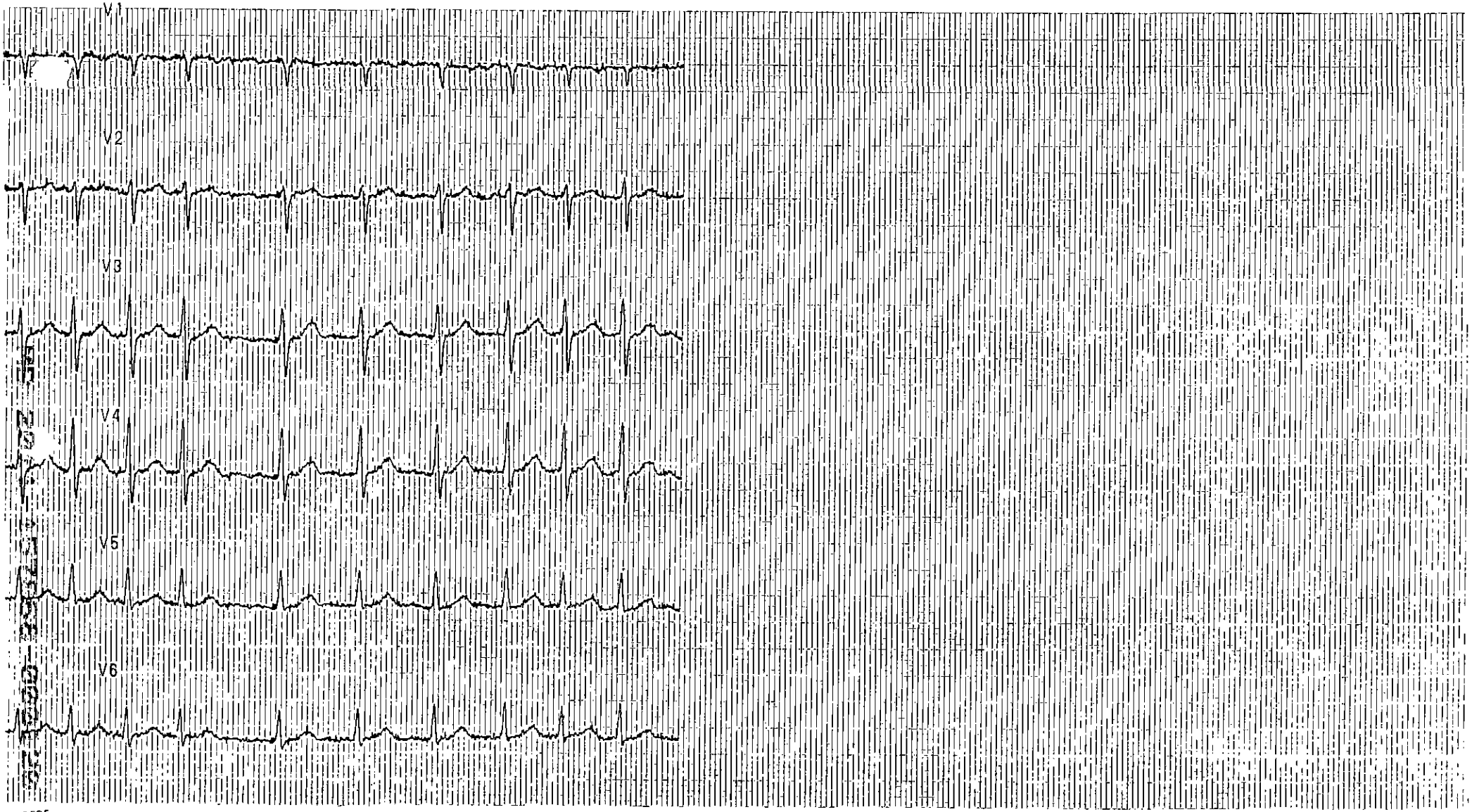


MADE IN USA

4 - Healthcare information read...

Name :
ID : [redacted]31352
13:4[redacted]/15/07
Speed: 25 mm/s ECG filter: Off
Gain : Limb 10 Chest 10 mm/mv

page 3



1-8505 .

MADE IN USA

PATIENT INFORMATION

NAME 4 - Healthcare information re...
AGE 70Y 4 - Healthcare information... SEX F
LAB NO. 4 - Healthcare inf...
PATIENT PHONE NO. 4 - Healthcare information re...
PT. NUMBER

PACLAB OLYMPIA
PACLAB
NETWORK LABORATORIES
500 Lily Rd. NE, Suite 170
Olympia, Washington 98506
(360) 456-1900 (800) 874-2969
FAX (360) 456-2740

CLIENT INFORMATION

LITTLEROCK FAMILY MEDICINE
LFM
6981 LITTLEROCK RD SW STE 101
TUMWATER, WA 98512

HARRIS,W KIRK MD

REPORTED	PAGE
01/19/2007 08:50	1

TESTS REQUESTED:
H72164 ORDERS: AHEML,CMPL,TSHL
COL: 01/18/2007 11:00 REC: 01/18/2007 11:20

TEST NAME	RESULTS OUT OF RANGE	RESULTS IN RANGE	UNITS	REFERENCE
COMPREHENSIVE METAB. PANEL				
GLUCOSE	H	115	mg/dL	65-99
If Pregnant, Normal=65 to 94 mg/dL. For additional diagnostic criteria, see the PAML test directory (www.paml.com)				
BUN	H	25	mg/dL	7-23
CREATININE	H	1.8	mg/dL	0.6-1.2
CALCIUM		9.5	mg/dl	8.5-10.5
AST		38	U/L	5-40
ALT		41	U/L	5-50
ALK PHOSPHATASE		45	U/L	38-110
BILIRUBIN, TOTAL	H	1.4	mg/dL	0.2-1.1
PROTEIN, TOTAL		6.8	g/dL	6.1-7.8
ALBUMIN		3.6	g/dL	3.3-4.8
SODIUM		141	mmol/L	135-145
POTASSIUM		4.6	mmol/L	3.5-5.3
CHLORIDE		105	mmol/L	98-109
CO2		28	mmol/L	22-31
ANION GAP		8		2-11
AUTOMATED CELL COUNT				
WBC		7.8	K/uL	4.0-11.0
RBC		4.66	M/uL	3.80-5.20
HEMOGLOBIN		14.6	g/dL	11.6-15.5
HCT		44.1	%	35.0-46.0
MCV		94.7	fL	80.0-100.0
MCH		31.4	pg	27.0-34.0
MCHC		33.2	g/dL	32.0-35.5
RDW		11.8	%	11.0-15.0
PLATELET COUNT		274	K/uL	150-400
THYROID STIM. HORMONE				
TSH		4.31	uIU/mL	0.40-5.00

4 - Healthcare information readi...

END OF REPORT

WKHpc

PAGE 1

Pt Has appt on 2/13/07 @ 10a

CHARLES A. RICHERT, M.D., MEDICAL DIRECTOR

PATIENT INFORMATION	
NAME	4 - Healthcare information readi...
AGE	70Y 4 - Healthcare information ... SEX F
LAB NO.	4 - Healthcare in...
PATIENT PHONE NO. :	4 - Healthcare informati...
PT. NUMBER	

PACLAB OLYMPIA

PACLAB NETWORK LABORATORIES

500 Lily Rd. NE, Suite 170
Olympia, Washington 98506
(360) 456-1900 (800) 874-2969
FAX (360) 456-2740

CLIENT INFORMATION

LITTLEROCK FAMILY MEDICINE
LFM
6981 LITTLEROCK RD SW
TUMWATER, WA 98512

HARRIS,W KIRK MD

REPORTED	PAGE
07/24/2006 08:50	1

TESTS REQUESTED:
F32123 ORDERS: LIPOPL
COL: 07/21/2006 09:45 REC: 07/21/2006 10:33

TEST NAME	RESULTS OUT OF RANGE	RESULTS IN RANGE	UNITS	REFERENCE
ORDER COMMENT: FASTING				
LIPID PROFILE				
CHOLESTEROL		190	mg/dL	<200
<200: Desirable				
200 to 239: Borderline high				
>239: High				
TRIGLYCERIDES	H 152		mg/dL	<150
<150: Normal				
150 to 199: Borderline High				
200 to 499: High				
>499: Very High				
HDL		40	mg/dL	40-59
<40: Low				
40 to 59: Normal				
>59: High				
HDL Cholesterol greater than or equal to 60 mg/dL is considered a "negative" risk factor, serving to remove one risk factor from the total count.				
LDL (CALCULATED)		120	mg/dL	
Normal Range: <100 mg/dL				
100 to 129: Near or above optimal				
130 to 159: Borderline High				
160 to 189: High				
>189: Very High				
To calculate 10 year cardiac risk for this patient, go to http://www.paml.com. Click on Testing, then on Ranges/Algorithms and then on Lipid Results.				

4 - Healthcare information readily ...

END OF REPORT

PAGE 1

CHARLES A. RICHERT, M.D., MEDICAL DIRECTOR

967 Mabury Road
San Jose, CA 95133
(408) 288-9850
(800) 234-5445
3714 Northgate Blvd.
Sacramento, CA 95834
(916) 927-9900
(800) 952-5691

Patient Name: NOT GIVEN
NOT GIVENFASTING
Age/DOB: PT PHONE #:
Sex:

SS #: NOT GIVEN

Client: KARL MOLIN, M.D.

MOLIN, KARL E.
707-448-8471

Accession No: GM3313690
Collected: 07/13/04 10:30
Received: 07/13/04 15:05
Reported: 07/14/04 08:09
Re-reported: FINAL 1
Report Status: Page

Requisition #: Not Given

	In Range	Out of Range		Reference	Units	PS
AGE AND/OR SEX NOT KNOWN. FOR TESTS WITH REFERENCE RANGES WHICH VARY AS A FUNCTION OF AGE OR SEX, WE CANNOT PROVIDE AGE OR SEX-SPECIFIC REFERENCE RANGES.						
LIPID PROFILE						
LIPID PROFILE						
CHOLESTEROL, TOTAL		299	H	(200	mg/dL	SC
TRIGLYCERIDES		257	H	(150	mg/dL	SC
VLDL CHOLESTEROL (CALCULATED)		51	H	5 - 40	mg/dL	SC
LDL CHOLESTEROL (CALCULATED)		209	H	0 - 129	mg/dL	SC
CHOLESTEROL, HDL		39	L	)40	mg/dL	SC
CHOLESTEROL/HDL RATIO	7.7					SC
CARDIAC RISK FACTOR				CHOL/HDL RATIO MALE / FEMALE		
LOW RISK				(3.5 / (3.5		
BELOW AVERAGE RISK				3.5-4.4 / 3.5-4.4		
AVERAGE RISK				4.5-6.4 / 4.5-5.5		
ABOVE AVERAGE RISK				6.5-13.5 / 5.6-11.0		
HIGH RISK				)13.5 /)13.5		
LDL/HDL RATIO	5.36					SC
CARDIAC RISK FACTOR				LDL/HDL MALE / FEMALE		
1/2 AVERAGE RISK				1.00 / 1.47		
AVERAGE RISK				3.55 / 3.22		
2X AVERAGE RISK				6.25 / 5.03		
3X AVERAGE RISK				7.99 / 6.14		
A handwritten non-specific test order was received. If this is not what you intended to order, please contact your local client service representative immediately so that we can adjust our billing appropriately. You may also inquire about alternative or additional testing.						
HEPATIC FUNCTION						
HEPATIC FUNCTION PANEL						
TOTAL PROTEIN	7.4			6.0-8.3	g/dL	SC
ALBUMIN	4.1			3.2-5.1	g/dL	SC
AST (SGOT)	17			8-50	U/L	SC
BILIRUBIN, TOTAL	0.7			0.2-1.5	mg/dL	SC
BILIRUBIN, DIRECT	0.1			0.0-0.3	mg/dL	SC
ALT (SGPT)	19			8-60	U/L	SC
ALKALINE PHOSPHATASE	59			20-125	U/L	SC
A handwritten non-specific test order was received. If this is not what you intended to order, please contact your local client service representative immediately so that we can adjust our billing						

REPORT CONTINUED ON NEXT PAGE / LEGEND ON LAST PAGE

GM3313690

MD 2011-157968-000129

967 Mabury Road
San Jose, CA 95133
(408) 288-9850
288-8008
3714 Northgate Blvd.
Sacramento, CA 95834
(916) 927-9900
(800) 952-5691

4 - Healthcare information readily...

Patient Name: NOT GIVEN
NOT GIVENFASTING
Age/DOB: PHONE #: 4 - Healthcare inf...
Sex:

SS #: NOT GIVEN

KARL MOLIN, M.D.
Client:

4 - Healthcare information readily identifiabl...

MOLIN, KARL E.
707-448-8471

GM3313690
Accession No:
Collected: 07/13/04 10:30
Received 07/13/04 15:05
Reported 07/14/04 08:09
Re-reported:
Report Status: FINAL
Page: 2

Test	In Range	Out of Range		Reference	Units	PS
appropriately. You may also inquire about alternative or additional testing.						
SODIUM, SERUM	141			135-146	mmol/L	SC
POTASSIUM, SERUM	4.6			3.5-5.3	mmol/L	SC
CHLORIDE, SERUM	104			98-110	mmol/L	SC
CARBON DIOXIDE (CO2)	21			16-26	mmol/L	SC
				NOTE NEW REFERENCE RANGE		
UREA NITROGEN, BLOOD (BUN)		29	H	7-25	mg/dL	SC
CREATININE, SERUM	1.3			0.5-1.4	mg/dL	SC
GLUCOSE		113	H	65-99	mg/dL	SC
				FASTING GLUCOSE CUTOFF RANGES		
				NORMAL: 65-99 mg/dL		
				IMPAIRED: 100-125 mg/dL		
				DIABETES:)125 mg/dL		

PLEASE NOTE THE FASTING GLUCOSE REFERENCE RANGE HAS BEEN CHANGED TO 65-99 mg/dL, BASED ON THE NEW GUIDELINES IN DIABETES CARE, A PUBLICATION OF THE AMERICAN DIABETES ASSOCIATION, IN ISSUE VOLUME 26, NUMBER 11, NOVEMBER 2003.

PERFORMING SITE

SC - Quest Diagnostics, 3714 Northgate Boulevard, Sacramento, CA 95834
Gerald E. Simon, M.D., (800) 952-5691

LAST PAGE OF REPORT

13313690 4 - Healthcare information readil...

MD 2011-157968-00012

Littlerock Famiiy Medicine
Urgent Care South

Open 8am to 9pm

Dr W Kirk Harris

6981 Littlerock Road SW, Ste. 101
Tumwater, WA 98512
Tel: 360-943-3633
Fax: 360-528-4643
NPI: 158 866 2068

Date: 4.26.11
To: Ortho Surgeon
FAX: 493.0407
From: LFM
Regarding: Pt
Person Faxing:
Pages: CA

4 - Healthcare information readily identifiable to a ...

Info on pt's hip surgery. She asked us to fax it to your office.

This facsimile transmission and accompanying documents may contain CONFIDENTIAL INFORMATION belonging to the sender which is protected by the PHYSICIAN/PATIENT PRIVILEGE. The information is intended for the use of the individual or entity named above. If you are not the intended recipient you are hereby notified that any disclosure, copying, distribution, or the taking of any action in reliance on the contents of this information is strictly prohibited by law. If you have received this transmission in error, please notify us by phone as soon as possible to arrange for the return of the document.

1800

OPERATIVE REPORT

DATE OF OPERATION: 10/26/2001

PREOPERATIVE DIAGNOSIS:	Severe osteoarthritis right hip.
POSTOPERATIVE DIAGNOSIS:	Severe osteoarthritis right hip.
OPERATION PERFORMED:	Right total hip replacement using the Zimmer cemented system, 12 stem, 0 mm x 28 mm neck head, 10 mm centralizer, 50 mm cup with 20 degree posterior offset liner.
OPERATING SURGEON:	JOHN C. KOFOED, M.D.
ASSISTANT:	DAVID GUZMAN, D.P.M.
ANESTHESIA:	General.
ANESTHESIOLOGIST:	DR. CHEN.

INDICATIONS: Severe osteoarthritis right hip.

DESCRIPTION OF PROCEDURE: Patient prepped and draped in the usual sterile fashion. Standard posterolateral incision made. Soft tissues reflected and the hip exposed. The external rotators and capsule reflected posteriorly off of the hip which was then dislocated and cut with the power saw. We then the used the _____ retractor to expose the acetabulum and reamed up to a 48 mm size and press fit a 50 mm screw in to the cup. I chose to put one single screw in to control rotation and there was an excellent bite. We then put in a 10 mm temporary posterior offset liner.

We then prepared the femur using the box chisel followed by the centralizer followed by the broaching up to 12. We tested our neck length and selected a size 0. We removed all components, bottle brushed the canal followed by the cement restrictor followed by the irrigation followed by the drying of the canal while the cement was being mixed, 2 bags of cement with 2 bottle of Tobramycin, which were then press fit into the canal with compression technique. We then placed in our femoral component, removing extraneous cement. While the cement was drying, we irrigated the hip extensively. We then tried our neck and head with noting good stability and position. There was

excellent stability throughout the hip. There was some concern about some posterior exposure of the femoral head at maximum flexion of 120 degrees and because of her large size, I chose to put in a 20 degree posterior offset liner which added a little bit more coverage posteriorly. The hip was very difficult to dislocate. With 40 degrees of internal rotation and adduction the hip was still in and at 120 degrees of flexion the hip was still in place. The wound was again irrigated extensively and closed in routine fashion over an auto-transfusion drain. Ancef 1 gm at the beginning of the procedure. Patient discharged to the recovery room in satisfactory condition.

JOHN C. KOFOED, M.D.

JCK/MRC72
The MRC Group
DD: 10/26/2001 11:34
DT: 10/26/2001 16:12
#85182

Littlerock Family Medicine
Urgent Care South

Open 8am to 9pm

Dr W Kirk Harris

6981 Littlerock Road SW, Ste. 101
Tumwater, WA 98512
Tel: 360-943-3633
Fax: 360-528-4643
NPI: 158 866 2068

Date: 4-21-11
To: nancy
FAX: 707-446-5041 / 707-446-5040
From: nesha
Regarding: 4 - Healthcare information readily identifiable to a perso... Jan 2004 hip replacement
Person Faxing: nesha
Pages: 2

FAXED 4-21-11 NB

This facsimile transmission and accompanying documents may contain CONFIDENTIAL INFORMATION belonging to the sender which is protected by the PHYSICIAN/PATIENT PRIVILEGE. The information is intended for the use of the individual or entity named above. If you are not the intended recipient you are hereby notified that any disclosure, copying, distribution, or the taking of any action in reliance on the contents of this information is strictly prohibited by law. If you have received this transmission in error, please notify us by phone as soon as possible to arrange for the return of the document.

Authorization for _____
Disclose My Health Care Information

Address: PH # 4 - Healthcare information readily id...

Patient name: 4 - Healthcare information readily identifiable to a person - RCW 4... Date of birth:

Previous name: _____

I. My Authorization

You may use or disclose the following health care Information (check all that apply):

- ☒ All health care Information in my medical record
- ☐ Health care information in my medical record relating to the following treatment or condition: _____
- ☐ Health care information in my medical record for the date(s): _____
- ☐ Other (e.g., X rays, bills), specify date(s): _____

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

- ☐ HIV (AIDS virus)
- ☐ Sexually transmitted diseases
- ☐ Psychiatric disorders/mental health
- ☐ Drug and/or alcohol use

You may disclose this health care information to:

Name : ✓ Littlerock Family Medicine Dr. W. Kirk Harris MD

Address: 6981 Littlerock RD SW Suite 101 City: Tumwater State: WA Zip: 98512

Reason(s) for this authorization (check all that apply):

- ☐ at my request
- ☐ other (specify) _____
- ☐ Transfer Medical Care to Dr. Harris.
- ☐ check only if _____ will be paid or get something of value for providing health information for marketing purposes

- ☐ **This authorization ends:** *(This document does not permit disclosure of health information created more than 90 days after the date it is signed.)*
- ☐ in 90 days from the date signed
- ☐ on (date): _____
- ☐ when the following event occurs: _____ (no longer than 90 days from date signed)

II. My Rights

I understand I do not have to sign this authorization In order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study or
- To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by [name of practice or health care facility] based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from the [practice/health care facility]. Or
- Write a letter to the [practice/health care facility].

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____

Patient or legally authorized individual signature | Date | Time

_____ _____

Printed name if signed on behalf of the patient | Relationship (parent, legal guardian, personal representative)

Last Update:___/___/___

* * * Communication Result Report (Apr. 25. 2011 1:44PM) * * *

1) Littlerock Family Medicine
2) W Kirk Harris M. D.

Date/Time: Apr. 25. 2011 1:43PM

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3928	Memory TX	17076465041	P. 2	OK	

Reason for error
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E. 2) Busy
E. 3) No answer
E. 4) No facsimile connection
E. 5) Exceeded max. E-mail size

Littlerock Family Medicine
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Dr W Kirk Harris

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FAXED 4-21-11 nb

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CASCADE FOOT & ANKLE CLINIC

Loren B. Stone, JR., D.P.M.

4 - Healthcare information r... **DOB:** 4 - Healthcare i... **03/09/2011**

Subjective: The patient is a 75-year-old female. She presents with considerable pain to the right great toe from gout. She started having gout problems, again, about a week or more ago. She has had a very large area of tophi to the dorsal aspect of the third toe right foot just proximal to the nail plate. She states this area is not painful. It is the right great toe that has been very painful in the past few days. She has considerable redness to the right great toe and more to the distal one half but she appears swollen around the first metatarsal phalangeal joint. She states this whole area has been quite painful to walk on the past few days. She has been to her physician, Dr. Harris in Tumwater and he started her on allopurinol 100 mg tablets daily. However, he increased her allopurinol to two 100 tablets daily a few days ago. But she states this has gotten worse as far as the pain, redness, swelling. It is more difficult to walk on the right foot. She states she is a diabetic and takes oral medication for this.

Assessment: Diabetic type II. Probable acute gout right foot around the first metatarsal phalangeal joint and great toe and possibly across the other metatarsal phalangeal joints as well. Gouty tophi to the end of the third toe right foot.

Plan: I examined both feet. I discussed the condition of the right foot with her. I called and discussed her condition with Dr. Harris. He suggested to increase her to 3-100 mg tablets of allopurinol daily and we discussed the use of colchicine 0.6-mg tablets and to place her on 7 days of the medication, taking it one tablet b.i.d.. Also the patient is to get an appointment to see Dr. Harris next week. I told her that I would be out of town for two weeks but if she wanted to come back in about 3 weeks we could possibly address the gouty tophus in the third toe at a later time but that she needed to get her acute gout condition under control.

Loren B. Stone Jr., DPM

CC Kirk W. Harris, MD
Littlerock Family Medicine
Tumwater, Wa.

CLINICAL NOTES

PROGRESS NOTE
BRENNAN, WILLIAM P M.D.
12/01/2010

4 - Healthcare information readily...
143-249-508
4 - Healthcare i...

REFERRING PHYSICIAN: W Kirk Harris MD

ACTIVE PROBLEMS:
1. Rule Out Coronary Artery Disease Characterized By;
   a. Class-3 limiting effort angina and dyspnea;
   b. Positive Myoview with ST segment depression and chest pain with Lexiscan effusion images pending;
   c. Resting anterolateral ST segment depression.
2. Diabetes Mellitus, Type-2.
3. Hypertension.
4. Hypercholesterolemia.

REASON FOR VISIT:
CAD-Art Bypass Graft
DM Non-Insulin Controlled
Hypertension Controlled
Hypercholesterolemia

HPI:
4 - Health... returns today post bypass surgery. She presented with Class III angina. Her angiography demonstrated aortic stenosis with a valve area of 0.6, a gradient of 55. She underwent aortic valve replacement with minimally invasive sternotomy and a Hancock 2 bioprosthesis 21.0 mm by Dr. Quinton 11/10. She had some early postoperative atrial fibrillation but then converted and eventually was discharged to home after a few days. She has done well since she has been home. She has some chest soreness but no anginal pain similar to what she had prior to her surgery. She did not require any bypasses at the time of surgery. She denies orthopnea, PND, peripheral edema.

CURRENT MEDICATIONS:
FLUOXETINE CAP 40mg 1 CAP PO QDAY in the morning
METFORMIN TAB 500mg 1 TAB PO BID with morning and evening meals
SIMVASTATIN TAB 20mg 1 TAB PO QDAY in the evening
ASA 325mg 1 TAB PO QDAY
NITROGLYCERIN SUBLINGUAL TAB 0.4mg Place 1 TAB SL at the 1st sign of an attack - may repeat every 5 min until relief up to a maximum of 3 doses
METOPROLOL TARTRATE TAB 25mg 1 TAB PO BID
PEPCID TAB 20mg 1 TAB PO BID
AMIODARONE TAB 200mg 1 TAB PO BID
FUROSEMIDE TAB 40mg 1 TAB PO QDAY
POTASSIUM CHLORIDE SR CAP 10meq 1 CAP QDAY

RECEIVED
DEC 08 2010

Allergies and Intolerances-- X-NKDA

REVIEW OF SYSTEMS: Pt says she is doing great - BS WKH 12/9/10

General- The patient reports fatigue, recent weight loss and sweats, but denies fevers or chills. Skin- No rashes. HEENT- The patient reports dizziness and hearing problems, but denies headaches or vision problems. Lungs- The patient reports orthopnea and DOE, but denies PND or wheezing. Heart- The patient reports chest pressure, heart murmurs and palpitations, but denies chest pain or heart murmur. GI- The patient reports loss of appetite, but denies bleeding from bowels, constipation, diarrhea, heartburn or indigestion. GU- No burning with urination, frequent urination or incontinence. Extremities- The patient reports arthritis, but denies ankle swelling or difficulty walking. Neuro- The patient reports difficulty with coordination and forgetfulness, but denies numbness or seizures. Psych- The patient reports anxiety and depression.

HABITS:
Tobacco- Never, Alcohol- Never

PHYSICAL EXAMINATION:
VITALS- BP 132/68 Pulse 64 (Initial RA Sitting Large Cuff), Weight 189 lbs, Height 63 inches, Bsa 1.95 m2, Bmi 33.48 kg/m2

CONSTITUTIONAL- The patient is well-appearing and is in no acute distress.
NECK- No significant JVD. No adenopathy.
CHEST- Grossly normal.
LUNGS- Clear to auscultation.
HEART
RHYTHM- Rhythm is regular.
PALPATION- PMI is within the MCL.
VALVES- S1 and S2 are normal.
GALLOPS- There is no S3 or S4.
AORTIC VALVE- Normal.
MITRAL VALVE- Normal.
ABDOMEN- Benign without hepatomegaly or splenomegaly.
EXTREMITIES- No clubbing, cyanosis or edema.
NEURO- Grossly intact.
PSYCH- Nonfocal and oriented to time and place without mood disturbance.

LIPID PROFILES:

	02/19/2009	05/27/2010	09/21/2010
CHOLESTEROL	-	-	-
HDL	-	-	-
LDL	-	-	-
SGOT	22	25	25
SGPT	19	24	25
TRIGLYCERIDES	-	-	-

IMPRESSION:
1. Status post aortic valve replacement, Dr. Quinton, 21.0-mm Hancock bioprosthesis, 11/10/10.
2. Organic heart disease prebypass surgery characterized by;
a. Angiography demonstrating peak gradient of 55, a valve area of 0.6 cm2, normal coronary arteries, ejection fraction 68%.
3. Other problems as above.

RECOMMENDATION:
The patient is doing well. We will get her enrolled in cardiac rehab. Otherwise, as listed.

PLAN:
1. Change to AMIODARONE TAB 200mg 1 TAB PO QDAY.
2. Followup Appointment in Olympia in 2 months.
3. Enroll in phase 2 rehab.

[Created: WILLIAM P BRENNAN M.D. on 12/01/2010 at 12:34 PM]
[Transcribed: CC on 12/02/2010 at 08:57 AM]
[Approved: PATRICIA BORN_RN for BRENNAN, WILLIAM P M.D. on 12/03/2010 at 11:11:15 AM]
[Finalized: 12/03/2010 at 11:11:15 AM]

cc.
W Kirk Harris MD|6981 Littlerock Road, #101|Tumwater, WA 98512

PATIENT REGISTRATION FORM DATE: 12-01-2010

ACCOUNT NUMBER: 931352-1

PRIMARY PRACTITIONER: 10 W. KIRK HARRIS, M.D.

PERSON RESPONSIBLE FOR BILL:

GUAR NAME:
GUAR ADDRESS:
SUITE APT:
CITY ST ZIP:
GUAR EMPLR: RETIRED

GUAR HOME PHONE:
GUAR WORK PHONE:

PATIENT INFORMATION:

PATIENT NAME:
PATIENT SSN:
DATE OF BIRTH:
PATIENT SEX F
PATIENT EMPLYR RETIRED

PAT HOME PHONE:
PAT WORK PHONE:
AGE: 74
MARITAL STATUS: S
PATIENT ID

REFERRED BY:

INSURANCE INFORMATION:

PRIMARY INS: MEDICARE PART B
POLICY HOLDER
EMPLOYER: RETIRED
SUBSCRIBER NO
GROUP NO:
INS COMMENT: $131 DED
BIRTH-DATE: SEX: F
RELATIONSHIP: SELF

SECONDARY INS: TRICARE FOR LIFE
POLICY HOLDER: TUITELE, MALUA
EMPLOYER: RETIRED
SUBSCRIBER NO:
GROUP NO:
INS COMMENT:
BIRTH-DATE: 10 SEX: M
RELATIONSHIP: SELF

12/1/10

We would like a Copy of notes on from your visits with Hu (any + all) Please if possible.

DOB

W. KIRK HARRIS, M.D.
6981 Littlerock Rd. S.W., Suite 101
Tumwater, WA 98512
Ph. 360-943-3633
Fax 360-528-4643

Talked c Janet RN (case manager) She states that Refused Services. c ADL's Grooming etc 12/1/10

Please review, sign, and return to:

Providence SoundHomeCare Adult
3432 South Bay Road NE
Olympia, WA 98506

Orders for:

4 - Healthcare information readily ident...

MR #: 00094065
Episode ID: 00046553
Location:

FAXED 11-28-10

Harris, William Kirk MD
6981 Littlerock Road Southwest
Suite 101
Tumwater, WA 98512

Order # 408186

Begin Date: 11/21/2010
Taken Date: 11/19/2010 12:00 AM
Entered Date: 11/19/2010 11:06 AM
End Date: 12/11/2010

For Order: OT 1 Week 3

OT to evaluate and treat for home safety, bath equipment including shower bench, grab bars, etc. VO per Lisa, per Dr Harris

---

Order # 408199

Begin Date: 11/21/2010
Taken Date: 11/19/2010 12:00 AM
Entered Date: 11/19/2010 11:14 AM
End Date: 01/15/2011

For Order: HA 2 Week 8

HHA for personal care, bathing, and home safety 2 x w x 8. VO per Lisa, per Dr. Harris.

Jamie
~~Amist~~

Janet Andrich-Case manager
Refused Care: 12/1/10

Order Employee Mary A Brown RN Date 11/19/2010
Brown, Mary A RN

PHYSICIAN
Order(s)
PLEASE SIGN AND DATE ALL PAGE(S) REQUESTED
THANK YOU

Physician Michelle Lee for Harris, MD Date 11/24/10
Harris, William Kirk MD
11-28-10

Entry Date: 11/19/2010

HH SN Routine (Visit 11/23/2010)

2129500722

HHSN RTN

Customer: 4 - Healthcare in...
Customer ID: 00094065
Admit ID: 00046553
DOB: 4 - Healthc...
SOC: 11/16/2010

Providence SoundHomeCare Adult
3432 South Bay Road NE
Olympia, WA 98506
6008697062

Contains
SN Routine (V5)
Prov Wound Assessment v5 #1
HH SN V3 STANDARD VISIT GUIDELINE Non-Visit
Plan For Next Visit

Date In: 11/23/2010 11:10:00AM
Date Out: 11/23/2010 11:35:00AM
Personnel: Andritch, Janet M RN

SN Routine (V5)

Clinical Record Items

Patient ID Number	00046553
Arrival Time	1110
Start of Care Date	11/16/2010
Date Assessment Completed	11/23/2010
Patient Name	4 - Health...
Discipline of Person Completing Assessment	1 - RN
Patient is Homebound	1 - Yes
Reason Patient is Homebound	1 - *Limited ambulation* 2 - Unsteady gait/poor balance
High Risk Factors	No changes
Living Arrangements and Support	No changes
Systolic Blood Pressure (1)	110
Diastolic Blood Pressure (1)	64
Blood Pressure taken in which Position (1)	Sitting
Blood Pressure taken in which Arm (1)	Left
Activity Level at which Blood Pressure was taken (1)	At rest
Blood Pressure Time Taken (1)	1115
Pulse (1)	72
Time Taken Pulse (1)	1115
Pulse (2)	69
Time Taken Pulse (2)	1110
Respirations	18
Time Taken Respirations	1115
Temperature	96.3
Time Taken Temperature	1115
Temperature Degrees measured in	Fahrenheit
Weight in Pounds	182
Weight is	Actual
Neuro	1 - Dizziness
Neuro notes	dizzy when she first sits up in bed, goes away quickly. No dizziness when standing or walking

Created: 11/23/2010 11:12:00AM
Completed: 11/23/2010 4:13:00PM
Printed: 12/1/2010 1:43:09PM

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Fall Risk Assessment - Delmarva Foundation and adapted by CIMRO of Nebraska. 8SOW-NE-HH-680

HH SN Routine (Visit 11/23/2010)

2129500722

Customer: 4 - Healthcare inf... Customer ID: 00094065 Admit ID: 00046553

Eyes	1 - Glasses
Ears	WNL
Oral	WNL
Nose and Sinus	WNL
Neck and Throat	WNL
Location of Pain (1)	sternal incision
Pain (1) Is	Acute
Pain Intensity (1)	5
Pain Control Measures (1)	1 - Rest 4 - Medication
Best Response to Control Measures (1)	1
Pain Radiate (1)	No
Describe Patient Pain	my chest hurts at times
Describe what pain is preventing patient from doing	housework.
Is there a pattern to the pain	No
Is there a time of day when pain is worse	night
Does pain vary	No
Is the Physician	aware
Skin Color	WNL
Skin Turgor	WNL
Skin Temperature	WNL
Skin Moisture	WNL
Braden Scale Sensory Perception	No impairment - Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.
Sensory Perception Score	4
Braden Scale Moisture	Rarely moist - Skin is usually dry; linen only requires changing at routine intervals.
Moisture Score	4
Braden Scale Activity	Walks frequently - Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.
Activity Score	4
Braden Scale Mobility	No limitations - Makes major and frequent changes in position without assistance.
Mobility Score	4
Braden Scale Nutrition	Adequate - Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered, OR is on a tube feeding or TPN regimen, which probably meets
Nutrition Score	3
Braden Scale Friction and Shear	No apparent problem - Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.
Friction and Shear Score	3
Braden Scale Total Score	22
Circulation	WNL
Heart Sounds	Regular
Peripheral Pulse	WNL
Capillary Refill	1 - Less than 3 seconds
Edema	None noted
Vascular Access	NA

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HH SN Routine (Visit 11/23/2010)

2129500722

Customer: 4 - Healthcare info... Customer ID: 00094065 Admit ID: 00046553

Conditions Affecting Respiratory Status	2 - Dyspnea
Breath Sounds	Clear bilaterally
Oxygen Saturation %	97
Productive Cough	0 - No
Conditions Affecting Genitourinary Status	WNL
Gastrointestinal Status	WNL
Conditions Affecting Elimination	WNL
Date of Last Bowel Movement	11/22/2010
Abdominal Status	WNL
Bowel Sounds	NA
Musculoskeletal	Weakness
Diet	diabetic
Diet Compliance	Compliant
Appetite	1 - Adequate
Nutritional Risk Assessment	1 - Takes three or more different prescribed/over the counter drugs
Total Nutritional Score (Refer to Legend For Results)	1
Nutritional Risk Status	0 - 2 Good - Recheck nutritional score in 6 months
Medication Compliance	1 - Compliant
	5 - Aware of purpose, proper use and possible side effects
Medication adverse effects/drug reaction	Non apparent/Patient denies
Home Monitoring Blood Glucose	Blood Glucose
Glucometer Reading	RBS 132
Venipuncture	NA
Supervisory Visit	NA

Prov Wound Assessment v5 #1

Clinical Record Items

Wound Location	#1 Sternun
Wound Stage	11/16/2010
Wound Type	11/23/2010
	Surgical wound
	4 - Healthcare info...
Appearance of Surrounding Tissue	Pink - normal for ethnic group
Wound Closure	None
Drainage Type	None
Drainage Amount	None
Drain(s) Present	No
Odor (After irrigation)	No
Tunneling / Sinus Tract	None
Appearance of Wound Bed	Edges approximated
Infection	No signs/symptoms of infection
Pressure redistribution in place	Not Applicable
Additional Documentation	#1 Sternal surgical incision is well approximated, scabs intact, no signs redness, no drainage, no swelling

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HH SN Routine (Visit 11/23/2010)

2129500722

Customer: 4 - Healthcare inf... Customer ID: 00094065 Admit ID: 00046553

Grouped Clinician Diagnosis: SN Altered Cardiovascular Function (Angina, CAD, AFib, MI, HTN, PVD)

Interventions

Intervention Category: ASSESS/EVALUATE — Identified: 11/16/2010 Achieved:

Achieved	Interventions	Performed	Var	Var Type	Rsn Code	Act Cod	Move to Next Visit
	SN Assess cardiovascular function.	Y	N				N

Intervention Category: INSTRUCT/TEACH — Identified: 11/16/2010 Achieved:

Achieved	Interventions	Performed	Var	Var Type	Rsn Code	Act Cod	Move to Next Visit
	SN Teach cardiac disease management.	Y	N				N

Note: Patient is weighing herself daily, verbalized understanding cardiac management. If weight increases 2lbs in 24hrs or 5lbs in 1 week, or experience SOB, or chest pain to contact MD.

Problems

Problem: EXPECTED OUTCOMES — Identified: 11/16/2010 Achieved:

Target	Achieved	Outcomes	Var	Var Type	Rsn Code	Act Cod
Within 3 weeks	11/23/2010	Patient/caregiver will verbalize edema management strategies.	N			
		Note: Patient verbalized understanding to help controll edema LEs she needs to elevate legs daily.				
Within 3 weeks	11/23/2010	Patient will weigh self daily and verbalize, without cues, when to call the doctor for weight gain.	N			
		Note: Patient is weighing herself daily, verbalized understanding cardiac management. If weight increases 2lbs in 24hrs or 5lbs in 1 week, or experience SOB, or chest pain to contact MD.				
Within 3 weeks	11/23/2010	Patient will demonstrate compliance with cardiac diet.	N			
		Note: Patient is currently following Diabetic, low sodium cardiac diet.				

Grouped Clinician Diagnosis: SN V3 Standard Visit Guideline

Interventions

Intervention Category: HHA SUPERVISION — Identified: 11/16/2010 Achieved:

Achieved	Interventions	Performed	Var	Var Type	Rsn Code	Act Cod	Move to Next Visit
11/23/2010	SN Confer with scheduler then notify patient regarding first planned bathing visit.	Y	N				N
	Note: Patient personal care is being managed by family, has declined HHA						

Intervention Category: ASSESS/TEACH — Identified: 11/16/2010 Achieved:

Achieved	Interventions	Performed	Var	Var Type	Rsn Code	Act Cod	Move to Next Visit
	STANDARD: SN 1. Document homebound status and 2. Document current status as reported by patient or cargiver. If not homebound contact supervisor.	Y	N				N
	Note: Patient is sitting in chair, awake oriented x3, states she is feeling good. She is getting assistance from family to help her with bathing and personal care needs. Has declined HHA						

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STANDARD: SN 1. Assess/teach patient/caregiver in medication management. 2. Document changes and any adverse interactions. 3. Educate high-risk medications, when and how to report problems that may occur.	Y	N	N
STANDARD: SN Assess vital signs every visit to include temperature, pulse, respirations, and blood pressure. Assess weight and O2 sats as ordered by physician.	Y	N	N
STANDARD: SN Assess pain and teach patient strategies to manage and mitigate. Document pain location, type, intensity scale, control measures, and best response every visit.	Y	N	N
Note: Has sternal pain at times 5 over 10, decreases to 1 over 10 after pain med taken. States feels like tenderness along incision, told her this was normal healing from having open heart surgery.			
STANDARD: SN Assess psychosocial and mental status including symptoms of depression as observed by the clinician or as reported by patient/caregiver.	Y	N	N
STANDARD: SN Assess for at-risk patient and teach prevention of ___ (pressure ulcers, falls, and diabetic foot ulcers).	Y	N	N
STANDARD: SN Assess respiratory status including breath sounds in all lung fields and dyspnea.	Y	N	N
Note: Breath sounds are CTA all lung fields, she does get SOB after walking approx 50ft, recovers withing 2 to 3mins rest.			
STANDARD: SN Assess cardiovascular status to include circulation, heart sounds, peripheral pulses and edema.	Y	N	N
Note: Breath sounds CTA all lung fields O2 SAT at rest 97 percent pulse 72, after walking approx 50 feet O2 SAT 96 pulse 90 slight SOB noted. After resting 3 mins O2 SAT 98 percent pulse 64			
STANDARD: SN Assess genitourinary status to include urine color and clarity.	Y	N	N
STANDARD: SN Assess skin integrity to include color, temperature, moisture and pressure.	Y	N	N

Problems

Problem: EXPECTED OUTCOMES Identified: 11/15/2010 Achieved:

Target	Achieved	Outcomes	Var	Var Type	Rsn Code	Act Cod
Within 3 weeks	11/23/2010	Patient/caregiver verbalizes knowledge of interventions and demonstrates ways to prevent pressure ulcers.	N			
		Note: Patient is walking 4 to 6 times in home daily, she is not et risk for getting pressure ulcers.				
Within 3 weeks	11/23/2010	Depression will be managed with current treatment plan.	N			
		Note: Denies being depressed				

HH SN Routine (Visit 11/23/2010)

2129500722

Customer: 4 - Healthcare inf... Customer ID: 00094066 Admit ID: 00046553

Grouped Clinician Diagnosis: WD V3 Surgical Wounds

Interventions

Intervention Category: ASSESS/EVALUATE Identified: 11/16/2010 Achieved:

Achieved	Interventions	Performed	Var	Var Type	Rsn Code	Act Cod	Move to Next Visit
	SN Assess current status of surgical wound(s) using Prov Wound Assessment: wound location(s) #1 midline chest Note: #1 Sternal surgical incision is well approximated, scabs intact, no signs redness, no drainage, no swelling	Y	N				N
	SN Assess for wound complications including infection.	Y	N				N

Intervention Category: INSTRUCT/TEACH Identified: 11/16/2010 Achieved:

Achieved	Interventions	Performed	Var	Var Type	Rsn Code	Act Cod	Move to Next Visit
	SN Teach patient/caregiver activity/mobility restrictions___. Note: Reminded patient to splint chest with pillow when getting up and sitting down, coughing or sneezes. She has tendency to forget pillow.	Y	N				N
	SN Teach patient/caregiver nutritional requirements for wound healing process. Consider dietary evaluation. Note: Sternal incision is well approximated, healing well	Y	N				N

Intervention Category: PERFORM Identified: 11/16/2010 Achieved:

Achieved	Interventions	Performed	Var	Var Type	Rsn Code	Act Cod	Move to Next Visit
11/23/2010	SN Perform surgical wound care to # 1 midline surgical incision - no dressing needed	N	N				N

Clinician Diagnoses

Resolved	Description
	SN V3 Standard Visit Guideline
	SN Altered Comfort
	WD V3 Surgical Wounds
	SN Altered Cardiovascular Function (Angina, CAD, AFib, MI, HTN, PVD)

Plan For Next Visit

assess Cardio/Pulm status
Assess stenal incision
Assess weight
Assess LE for s/s edema

Created: 11/23/2010 11:12:00AM Printed: 12/1/2010 1:43:14PM
Completed: 11/23/2010 4:13:00PM
Author: Andritch, Janet M RN

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HH OT Disc Add On Assessment (Visit 11/23/2010)

Z121900457

HHOT ADDON

Customer: 4 - Healthcare in...
Customer ID: 00094085
Admit ID: 00046553
DOB: 4 - Healthcare...
SOC: 11/16/2010

Providence SoundHomeCare Adult
3432 South Bay Road NE
Olympia, WA 98506
8008597062

Contains
Prov OT Assessment v3
HH OT ADD-ON GUIDELINE Non-Visit
Clinical Note

Date In: 11/23/2010 1:30:00PM
Date Out: 11/23/2010 2:30:00PM
Personnel: Blank, Lois J OT

Prov OT Assessment v3

Clinical Record Items	
Patient Name	4 - Healthcare inf...
Start of Care Date	11/16/2010
Patient ID	00094085
Date of Assessment	11/23/2010
Patient Date of Birth	02/10/1938
Primary Language	English
Patient's usual method of communication	1 - Speech
Communication Deficits	Not Assessed
Unusual Home/Social Environment	None
Structural barrier - Bathroom	Safe/Easy access
Structural barrier - Bedroom	Safe/Easy access
Structural barrier - Kitchen	Safe/Easy access
Structural barrier - Living room	Safe/Easy access
Structural barrier - Laundry facilities	Safe/Easy access
Safety Notes	full flight of stairs up to her living level of her home. Downstairs are 2 extra bedrooms and bath.
Shortness of Breath	None
Eyes	WNL
Ears	WNL
Neck and Throat	WNL
Visual Acuity	Testing deferred
Neurological Condition	WNL
Orientation	Oriented to person, place, time, and purpose.
Responsiveness	Alert
Attention	Normal
Short Term Memory	Normal
Long Term Memory	Normal
Judgement/Safety	Good
Awareness of Deficits	Good
Nutrition/Oral Motor Function	WNL
Appetite	1 - Good

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Printed: 12/1/2010 1:43:14PM

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HH OT Disc Add On Assessment (Visit 11/23/2010)

2121900457

Customer: 4 - Healthcare info... Customer ID: 00094065 Admit ID: 00046553

Conditions Affecting Dentition	WNL
Functional Limitations	6 - Endurance
	7 - Ambulation
Activities Permitted	B - Walker
Grooming Activities-Assistance	WNL
Dressing Upper Body	WNL
Dressing Lower Body Details-Assistance	WNL
Shower/Tub upper body	MI - Modified Independent
Shower/Tub lower body	MI - Modified Independent
Sponge upper body	MI - Modified Independent
Sponge lower body	MI - Modified Independent
Back	MI - Modified Independent
Shampoo hair	MI - Modified Independent
Clothing management	MI - Modified Independent
Cleansing	MI - Modified Independent
Transfer	MI - Modified Independent
Urinal	MI - Modified Independent
Bedpan	MI - Modified Independent
Feeding-Assistance	WNL
Meal Preparation	WNL
Leisure Time Management	WNL for Patient
Household Management	IND - Independent
	IND - Independent
Money management	IND - Independent
Writing	IND - Independent
Light switches/Lamps	IND - Independent
Pick up objects from floor	MI - Modified Independent
Trash	MAX - Maximum assist-participates minimally-unable to complete without significant assistance
Mail	IND - Independent
Elevator operation	MAX - Maximum assist-participates minimally-unable to complete without significant assistance
Household Management	MAX - Maximum assist-participates minimally-unable to complete without significant assistance
Brace	None
Wheeled Walker (Assist Device)	Has wheeled walker
Grab Bars [toilet/shower/tub] / (Assist Device)	Needs
Other [specify] notes	declined shower
Edema	None noted
Musculoskeletal	Weakness
Reflexes	Not tested
Joints	WFL
Coordination/Gross Motor Function	WFL
Muscle Tone/Sensation	WFL
Sensory Discrimination	WFL
Perceptual Motor Function	WFL
Range of motion/Strength limitations-Upper extremities	WNL
Range of motion/Strength limitations - wrist	WFL

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HH OT Disc Add On Assessment (Visit 11/23/2010)

2121900457

Customer: 4 - Healthcare info... Customer ID: 00094065 Admit ID: 00046553

Range of motion/Strength limitations - forearm	WFL
Functional Hand Assessment (RIGHT HAND) - Gross Grasp	WFL
Functional Hand Assessment (RIGHT HAND) - Gross Release	WFL
Range of Motion in Degrees (RIGHT HAND)	WFL
Functional Hand Assessment (LEFT HAND) - Gross Grasp	WFL
Functional Hand Assessment (LEFT HAND) - Gross Release	WFL
Range of Motion in Degrees (LEFT HAND)	WFL
Location of Pain (1)	chest
Pain (1) Is	Recent onset
Pain intensity (1)	1
Pain Control Measures (1)	1 - Rest
Best Response to Control Measures (1)	1
Is the Physician	aware
Devices currently used for Ambulation	5 - Wheeled walker
Wheelchair Mobility	NA
Bed Mobility	WNL for Patient
Sit to stand	MI - Modified Independent
Stand to sit	MI - Modified Independent
Bed to chair/wheelchair	NA
Chair/wheelchair to bed	NA
Bed to commode	NA
Shower/tub	MI - Modified Independent
Toilet	MI - Modified Independent
Transfers Comments	using pillow on chest
Balance	WFL
History of Falls - Last 3 months	No
Fall Risk Consciousness/Mental Status	0 - Alert - (oriented x 3) or Comatose
Fall Risk Consciousness/Mental Status Score	0
Fall Risk History of Falls	0 - No falls (in past 3 months)
Fall Risk History of Falls Score	0
Fall Risk Ambulation/Elimination Status	0 - Ambulatory/continent
Fall Risk Ambulation/Elimination Status Score	0
Fall Risk Vision	0 - Adequate (with or without glasses)
Fall Risk Vision Score	0
Fall Risk Gait/Balance	1 - Requires use of assistive device (cane, w/c, furniture...)
Fall Risk Gait/Balance Score	1
Fall Risk Systolic Blood Pressure	0 - No noted drop between lying and standing
Fall Risk Systolic Blood Pressure Score	0
Fall Risk Medications	2 - Takes 1-2 of these medications currently and/or w/in last 7 days
Fall Risk Medications Score	2
Fall Risk Predisposing Diseases	2 - 1 - 2 present
Fall Risk Predisposing Diseases Score	2
Fall Risk Total Score	5
Ambulation	WNL for Patient
Discipline Supervised	NA
Patient is Homebound	1 - Yes
Reason Patient is Homebound	1 - Limited ambulation

Created: 11/23/2010 2:17:00PM Printed: 12/1/2010 1:43:14PM
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HH OT Disc Add On Assessment (Visit 11/23/2010)

2121900457

Customer: 4 - Healthcare inf... Customer ID: 00094065 Admit ID: 00046553

Limited ambulation(ft)	100
Reason Patient Leaves Home	Physician's office
Plan of Care	Evaluation
Plan of Care Notes	nurse to follow up on 1 grab bar rec.
Safety Measures	4 - Implement a falls prevention program (e.g., remove throw rugs, teach safe use of assist/safety devices)
Plan of Care Reviewed with	1 - Patient

Grouped Clinician Diagnosis: OT Add-on Guideline

Interventions

Intervention Category: PERFORM (BY CLINICIAN) Identified: 11/23/2010 Achieved:

Achieved	Interventions	Performed	Var	Var Type	Rsn Code	Act Cod	Move to Next Visit
11/23/2010	OT Verify patient identity using 2 identifiers (name, social security number or birth date).	N	N				N
11/23/2010	OT Verify primary discipline has completed admission visit.	N	N				N
11/23/2010	OT Verify insurance authorization for add-on assessment present.	N	N				N
11/23/2010	OT Complete Prov OT Assessment.	N	N				N
11/23/2010	OT Review any home safety recommendations.	N	N				N
11/23/2010	OT Discuss Plan of Care with patient/caregiver.	N	N				N
11/23/2010	OT Discuss process of OT home health services, next steps and discharge planning.	N	N				N
11/23/2010	OT Contact attending physician for ongoing discipline orders and referral for additional services including HH Aide if appropriate.	N	N				N
11/23/2010	OT Complete insurance authorization request for additional visits.	N	N				N

Problems

Problem: EXPECTED OUTCOMES Identified: 11/23/2010 Achieved:

Target	Achieved	Outcomes	Var	Var Type	Rsn Code	Act Cod
	11/23/2010	Patient demonstrated/verbalized understanding of education regarding bathroom safety.	N			

Clinician Diagnoses

Resolved	Description
	OT Add-on Guideline

Created: 11/23/2010 2:17:00PM Printed: 12/1/2010 1:43:14PM
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HH OT Disc Add On Assessment (Visit 11/23/2010)

2121900457

Customer: 4 - Healthcare in... Customer ID: 00084065 Admit ID: 00046553

Clinical Note

74 YEAR OLD FEMALE TO HOME HEALTH FOLLOWING SURGERY FOR AORTIC STENOSIS AND AORTIC VALVE REPLACEMENT/SHE LIVES ALONE IN A TWO-STORY CONDO BUT MAINLY LIVES ON THE UPPER LEVEL/SHE HAS TWO SONS AND THEIR WIVES WHO ARE HELPING OUT -

COGNITION: INTACT
VISION AND HEARING:INTACT
PSYCH-SOCIAL SKILLS: PLEASANT AND SOCIAL
SAFETY JUDGMENT: NORMAL
ADLS: INDEPENDENT
IADLS: INDEPENDENT EXCEPT FOR FAMILY ASSIST WITH SHOPPING, CLEANING AND TRANSPORTATION
MOTOR: NORMAL UE USE
FUNCTIONAL MOBILITY: I IN HER HOUSE EXCEPT TO GO DOWN FULL FLIGHT OF STAIRS FOR SAFETY. IN A FIRE SHE COULD EXIT.

ASSESSMENT: PATIENT NEEDS 1 GRAB BAR IN BATHROOM. SHE WAS GIVEN # OF VENDOR TO DELIVER AND INSTALL. SAID HER SONS COULD NOT.

OT PLAN: EVAL ONLY.

Created: 11/23/2010 2:17:00PM Printed: 12/1/2010 1:43:14PM
Completed: 11/30/2010 9:26:00AM
Author: Blank, Lois J OT
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HH SN Routine (Visit 11/19/2010)

2129500864

HHSN RTN

Customer: 4 - Healthcare in...
Customer ID: 00094065
Admit ID: 00046553
DOB: 4 - Healthca...
SOC: 11/16/2010

Providence SoundHomeCare Adult
3432 South Bay Road NE

Olympia, WA 98506

6008897062

Contains
SN Routine (V5)
Prov Wound Assessment v5 #1
Prov Wound Assessment v5 #2
HH SN V3 ADMISSION GUIDELINE Non-Visit
HH SN V3 STANDARD VISIT GUIDELINE Non-Visit
Plan For Next Visit

Date In: 11/19/2010 11:40:00AM
Date Out: 11/19/2010 12:25:00PM
Personnel: Andritch, Janet M RN

SN Routine (V5)

Clinical Record Items

Patient ID Number	00046553
Arrival Time	1140
Start of Cere Date	11/16/2010
Date Assessment Completed	11/19/2010
Patient Name	4 - Health...
Discipline of Person Completing Assessment	1 - RN
Reason Patient is Homebound	1 - Limited ambulation 2 - Unsteady gait/poor balance 3 - SOB with minimal exertion
High Risk Factors	No changes
Living Arrangements and Support	No changes
Systolic Blood Pressure (1)	118
Diastolic Blood Pressure (1)	70
Blood Pressure taken in which Position (1)	Sitting
Blood Pressure taken in which Arm (1)	Left
Activity Level at which Blood Pressure was taken (1)	At rest
Systolic Blood Pressure (2)	112
Diastolic Blood Pressure (2)	72
Blood Pressure taken in which Position (2)	Standing
Blood Pressure taken in which Arm (2)	Left
Pulse (1)	64
Time Taken Pulse (1)	1200
Location Pulse was Taken (1)	1 - Apical
Activity Level at which Pulse was taken (1)	1 - At rest
Characteristic of Pulse (1)	1 - Regular
Pulse (2)	60
Time Taken Pulse (2)	1155
Respirations	18
Time Taken Respirations	1200
Oxygen Use	None

Created: 11/19/2010 11:45:00AM
Completed: 11/19/2010 3:42:00PM
Printed: 12/1/2010 1:43:14PM

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HH SN Routine (Visit 11/19/2010)

2129500664

Customer: 4 - Healthcare inf... Customer ID: 00094066 Admit ID: 00046563

Temperature	97.2
Time Taken Temperature	1155
Temperature Degrees measured In	Fahrenheit
Height In Feet	5
Inches	3
Weight in Pounds	186.6
Weight is	Actual
Neuro	WNL
Eyes	1 - Glasses
Oral	WNL
Nose and Sinus	WNL
Neck and Throat	WNL
Location of Pain (1)	sternum
Pain (1) Is	Acute
Pain Intensity (1)	7
Pain Control Measures (1)	1 - Rest 4 - Medication
Best Response to Control Measures (1)	1
Pain Radiate (1)	No
Describe Patient Pain	It is just like catching my breath, I feel like I have been in a fight
Describe what pain is preventing patient from doing	daily living activites, housework, cooking, shopping
How long does patients pain last	1 to 2 hrs
Is there a pattern to the pain	No
Is there a time of day when pain is worse	all the times
Does pain vary	No
the Physician	aware
Skin Color	WNL
Skin Turgor	WNL
Skin Temperature	WNL
Skin Moisture	WNL
Braden Scale Sensory Perception	No impairment - Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.
Sensory Perception Score	4
Braden Scale Moisture	Rarely moist - Skin is usually dry; linen only requires changing at routine intervals.
Moisture Score	4
Braden Scale Activity	Walks frequently - Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.
Activity Score	4
Braden Scale Mobility	No limitations - Makes major and frequent changes in position without assistance.
Mobility Score	4
Braden Scale Nutrition	Adequate - Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered, OR is on a tube feeding or TPN regimen, which probably meets
Nutrition Score	3
Braden Scale Friction and Shear	No apparent problem - Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.

Created: 11/19/2010 11:45:00AM Printed: 12/1/2010 1:43:14PM
Completed: 11/19/2010 3:42:00PM
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Risk Assessment - Delmarva Foundation and adapted by CIMRO of Nebraska. BSOW-NE-HH-680

HH SN Routine (Visit 11/19/2010)

2129500664

Customer: 4 - Healthcare inf... Customer ID: 00094065 Admit ID: 00046553

Friction and Shear Score	3
Braden Scale Total Score	22
Conditions Affecting Cardiovascular Status	1 - Fatigue
Heart Sounds	Regular
Peripheral Pulse	WNL
Capillary Refill	1 - Less than 3 seconds
Edema	None noted
Vascular Access	NA
Conditions Affecting Respiratory Status	2 - Dyspnea
Breath Sounds	Clear bilaterally
Oxygen Saturation %	94
Productive Cough	0 - No
Conditions Affecting Genitourinary Status	1 - Urgency
	2 - Frequency
Gastrointestinal Status	WNL
Conditions Affecting Elimination	WNL
Abdominal Status	WNL
Bowel Sounds	WNL
Musculoskeletal	Weakness
Diet	diabetic
Diet Compliance	Compliant
Appetite	1 - Adequate
Nutritional Risk Assessment	1 - Takes three or more different prescribed/over the counter drugs
Total Nutritional Score (Refer to Legend For Results)	1
Nutritional Risk Status	0 - 2 Good - Recheck nutritional score in 6 months
Medication Compliance	1 - Compliant
	5 - Aware of purpose, proper use and possible side effects
Medication adverse effects/drug reaction	Non apparent/Patient denies
Home Monitoring Blood Glucose	Blood Glucose
Glucometer Reading	RBS 135
Home Monitoring Notes	aver 95 to 110 per patient
Venipuncture	NA
Supervisory Visit	NA

Prov Wound Assessment v5 #1

Clinical Record Items

Wound Location	#1 Sternum
Wound Stage	11/16/2010
Wound Type	11/19/2010
	Surgical wound
	Tuitele, Joyce
Appearance of Surrounding Tissue	Pink - normal for ethnic group
Appearance of Surrounding Tissue Other	bruising

HH SN Routine (Visit 11/19/2010)

2129500664

Customer: 4 - Healthcare inf... Customer ID: 00094065 Admit ID: 00046553

Wound Closure	None
Drainage Type	None
Drainage Amount	None
Drain(s) Present	No
Odor (After irrigation)	No
Tunneling / Sinus Tract	None
Appearance of Wound Bed	Edges approximated
Infection	No signs/symptoms of infection
Pressure redistribution in place	Not Applicable
Additional Documentation	#1 Sternal incision is well approximated, there is no drainage, no redness, some bruising seen on upper end of incision.

Prov Wound Assessment v5 #2

Clinical Record Items

Wound Stage	11/16/2010
Wound Type	11/19/2010

4 - Healthcare info...

Grouped Clinician Diagnosis: SN Altered Cardiovascular Function (Angina, CAD, AFib, MI, HTN, PVD)

Interventions

Intervention Category: PERFORM (BY CLINICIAN) Identified: 11/16/2010 Achieved:

Achieved	Interventions	Performed	Var	Var Type	Rsn Code	Act Cod	Move to Next Visit
	SN Perform oximetry q 6nv at rest and with ambulation	Y	N				N
	Note: O2 SAT at rest 94 percent, unable to get O2 SAT after walking approx 50 ft due to oximeter would not work.						

Grouped Clinician Diagnosis: SN Altered Comfort

Interventions

Intervention Category: ASSESS/EVALUATE Identified: 11/16/2010 Achieved:

Achieved	Interventions	Performed	Var	Var Type	Rsn Code	Act Cod	Move to Next Visit
	SN Assess Patient/caregiver ability to monitor and manage pain effectively.	Y	N				N

Intervention Category: INSTRUCT/TEACH Identified: 11/16/2010 Achieved:

Achieved	Interventions	Performed	Var	Var Type	Rsn Code	Act Cod	Move to Next Visit
	SN Teach methods to mitigate and control pain.	Y	N				N

HH SN Routine (Visit 11/19/2010)

2129600664

Customer: 4 - Healthcare inf... Customer ID: 00004065 Admit ID: 00046553

Grouped Clinician Diagnosis: SN V3 Standard Visit Guideline

Interventions

Intervention Category: ASSESS/TEACH Identified: 11/15/2010 Achieved:

Achieved	Interventions	Performed	Var	Var Type	Rsn Code	Act Cod	Move to Next Visit
	STANDARD: SN 1. Document homebound status and 2. Document current status as reported by patient or caregiver. If not homebound contact supervisor.	Y	N				N
	Note: Patient is sitting in chair, alert and orriented x3, states she is feeling good but does have feeling tightness around surgical incision. Told her this was normal, that she is healing from inside out and would have some chest discomfort.						
	STANDARD: SN 1. Assess/teach patient/caregiver in medication management. 2. Document changes and any adverse interactions. 3. Educate high-risk medications, when and how to report problems that may occur.	Y	N				N
	STANDARD: SN Assess vital signs every visit to include temperature, pulse, respirations, and blood pressure. Assess weight and O2 sats as ordered by physician.	Y	N				N
	STANDARD: SN Assess pain and teach patient strategies to manage and mitigate. Document pain location, type, intensity scale, control measures, and best response every visit.	Y	N				N
	Note: Reports incisional pain at 7 over 10 after medicating with Vicodin decreases to 1 over 10. States it is just like catching my breath, I feel like I have been in a fight. She is taking pain med 1 to 2 times daily with good relief.						
	STANDARD: SN Assess psychosocial and mental status including symptoms of depression as observed by the clinician or as reported by patient/caregiver.	Y	N				N
	STANDARD: SN Assess for at-risk patient and teach prevention of ___ (pressure ulcers, falls, and diabetic foot ulcers).	Y	N				N
	Note: Instructed on Fall Precaution Procedures, and importance to us pillow to brace chest when she is getting up and down. Verbalized understanding						
	STANDARD: SN Assess respiratory status including breath sounds in all lung fields and dyspnea.	Y	N				N
	Note: Breath sounds are CTA all lung fields, she does get slightly SOB after exertion walking greater than 50ft, recovers quickly.						
	STANDARD: SN Assess cardiovascular status to include circulation, heart sounds, peripheral pulses and edema.	Y	N				N
	Note: Heart rate regular, has no edema bilat LEs, feet are warm to touch, color pink, good strong pedal pulses.						
	STANDARD: SN Assess genitourinary status to include urine color and clarity.	Y	N				N

HH SN Routine (Visit 11/19/2010)

2129600664

Customer: 4 - Healthcare inf... Customer ID: 00094065 Admit ID: 00046553

STANDARD: SN Assess gastrointestinal status to include date of last bowel movement and bowel sounds.	Y	N		N
STANDARD: SN Assess skin integrity to include color, temperature, moisture and pressure.	Y	N		N

Problems

Problem: EXPECTED OUTCOMES Identified: 11/15/2010 Achieved:

Target	Achieved	Outcomes	Var	Var Type	Rsn Code	Act Cod
Within 3 weeks	11/19/2010	Patient personal care needs met by discharge. Note: Patient is managing her personal care with help from family. Discussed if she would like HHA to help with bathng stated it was not needed.	N			
Within 3 weeks	11/19/2010	Patient/caregiver will verbalize understanding of fall risks and fall prevention and will take action to remove fall hazards from the home. Note: Instruction given on Fall Precaution Procedures, verbalized understanding.	N			

Grouped Clinician Diagnosis: WD V3 Surgical Wounds

Interventions

Intervention Category: ASSESS/EVALUATE Identified: 11/16/2010 Achieved:

Achieved	Interventions	Performed	Var	Var Type	Rsn Code	Act Cod	Move to Next Visit
	SN Assess current status of surgical wound(s) using Prov Wound Assessment: wound location(s) #1 midline chest Note: #1 Sternal Incision is well approximated, there is no drainage, no redness, some bruising seen on upper end of incision.	Y	N				N
	SN Assess for wound complicetions including infection.	Y	N				N

Intervention Category: INSTRUCT/TEACH Identified: 11/16/2010 Achieved:

Achieved	Interventions	Performed	Var	Var Type	Rsn Code	Act Cod	Move to Next Visit
	SN Teach patient/caregiver activity/mobility restrictions___. Note: Instructed to walk in apartment, 3 to 4 times daily, verbalized understanding	Y	N				N
	SN Teach patient/caragiver nutritional requirements for wound healing process. Consider dietary evaluation. Note: Instruction given on Low Sodium diet, verbalized understanding	Y	N				N
	SN Teach patient/caregiver surgical wound care and to report any changes in wound.	Y	N				N
	SN Teach patient/caregiver signs and symptoms of infection.	Y	N				N

Intervention Category: PERFORM Identified: 11/16/2010 Achieved:

Created: 11/19/2010 11:45:00AM Printed: 12/1/2010 1:43:14PM
Completed: 11/19/2010 3:42:00PM
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HH SN Routine (Visit 11/19/2010)

2129500664

Customer: 4 - Healthcare inf... Customer ID: 00094065 Admit ID: 00046553

Achieved	Interventions	Performed	Var	Var Type	Rsn Code	Act Cod	Move to Next Visit
	SN Perform surgical wound care to # 1 midline surgical incision - no dressing needed	Y	N				N

Note: #1 Sternal incision is well approximated, there is no drainage, no redness, some bruising seen on upper end of incision.

Problems

Problem: EXPECTED OUTCOMES Identified: 11/16/2010 Achieved:

Target	Achieved	Outcomes	Var	Var Type	Rsn Code	Act Cod
Within 3 weeks	11/19/2010	Patient/caregiver will verbalize understanding of adequate nutrition and hydration to promote healing of surgical wound by week 3___.	N			

Note: Patient verbalized understanding importance keeping well hydrated, and eating well balanced diet for good wound healing.

Within 3 weeks	11/19/2010	Patient/caregiver will demonstrate effective surgical wound care by week ___.	N			

Note: Sternal incsion is well approximate, no dreinage, no drsg needed.

Clinician Diagnoses

Resolved	Description
	SN V3 Admission Guideline
	SN V3 Standard Visit Guideline
	SN Altered Comfort
	WD V3 Surgical Wounds
	SN Altered Cardiovascular Function (Angina, CAD, AFib, MI, HTN, PVD)

Plan For Next Visit

Assess Cardio/Pulm status
Assess weight
Assess O2 SAT at rest and after activity
Assess compliance using heart pillow with activity

Created: 11/19/2010 11:45:00AM Printed: 12/1/2010 1:43:14PM
Completed: 11/19/2010 3:42:00PM
Author: Andritch, Janet M RN

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HH SN Start of Care (Visit 11/16/2010)

1512300367

HHSN SOC

Customer: 4 - Healthcare inf...
Customer ID: 00094065
Admit ID: 00046553
DOB: 4 - Healthc...
SOC: 11/16/2010

Providence SoundHomeCare Adult
3432 South Bay Road NE
Olympia, WA 98506

6008697062

Contains
SN SOC/ROC (OASIS-C version 02.00)
HH SN V3 ADMISSION GUIDELINE Non-Visit
HH SN V3 STANDARD VISIT GUIDELINE Non-Visit
Clinical Note
Plan For Next Visit

Date In: 11/16/2010 10:15:00AM
Date Out: 11/16/2010 11:45:00AM
Personnel: Alspaugh, Joan M RN

OASIS Assessment Items For SN SOC/ROC (OASIS-C version 02.00)

Oasis Correction: Not Extracted

Clinical Record Items

M0010 Agency Medicare ID	507004
M0014 Branch State	WA
M0016 Branch ID Number	P
(M0018) National Provider Identifier (NPI) for the attending physician who has signed the Plan of Care	1992756852
M0020 Patient ID Number	00046553
M0030 Start of Care Date	11/16/2010
M0032 Resumption of Care Date	NA - Not applicable
M0040 Patient Name	4 - Healt...
M0050 Patient State of Residence	4 -...
M0060 Patient Zip Code	4 - He...
M0063 Medicare Number	4 - Healthcare ... A
M0064 Patient Social Security Number	UK - Unknown or not available
M0066 Patient Date of Birth	02/10/1936
M0069 Patient Gender	2 - Female
M0140 Patient Race/Ethnicity	6 - White
M0150 Current Payment Sources for Home Care	1 - Medicare (traditional fee-for-service)
M0080 Discipline of Person Completing Assessment	1 - RN
M0090 Date Assessment Completed	11/16/2010
M0100 Reason for Assessment	1 - Start of care - further visits planned
(M0102) Date of Physician-ordered Start of Care (Resumption of Care)	11/16/2010
Homebound Status	1 - Yes
Reason Patient is Homebound	1 - Limited ambulation
Limited ambulation(ft)	20-30
Reason Patient Leaves Home	Physician's office
(M0110) Episode Timing: Is the Medicare home health payment episode for which this assessment will define a case mix group an "early" episode or a "later" episode in the patients current sequence of adjacent medicare home health payment episodes?	1 - Early
(M1000) From which of the following Inpatient Facilities was the patient discharged during the past 14 days?	3 - Short-stay acute hospital (IPPS)
(M1010) Inpatient Facility Diagnosis Description (a)	AORTIC STENOSIS

Created: 11/16/2010 5:00:00PM
Completed:
Printed: 12/1/2010 1:43:14PM

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HH SN Start of Care (Visit 11/16/2010)

1512300367

Customer: 4 - Healthcare inf... Customer ID: 00094065 Admit ID: 00046553

(M1012) Inpatient Procedure Description (a)	ATRIAL VALVE REPLACEMENT
(M1016) Changed Medical Regimen Diagnosis Description (a)	AORTIC STENOSIS
(M1016) Changed Medical Regimen Diagnosis Description (b)	NIDDM WITHOUT COMPLICATION
(M1018) Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay Within Past 14 Days:	7 - None of the above
(M1020) Primary Diagnosis Description (a)	OTHER AND UNSPECIFIED ANGINA PECTORIS
(M1020) Primary Diagnosis ICD-9-CM Code (a)	4139
(M1020) Primary Diagnosis Symptom Control Rating (a)	3
(M1030) Therapies the patient receives AT HOME	4 - None of the above
(M1036) Risk Factors, either present or past, likely to affect current health status and/or outcome	5 - None of the above
(M1100) Patient Living Situation	04 - Patient lives alone Occasional / short-term assistance
Caregiver Willing	Yes
Caregiver Willing - Specify	TWO SONS WHO LIVE IN AREA AND THEIR WIVES HAVE BEEN HELPING
Abuse / Neglect	No signs of abuse/neglect/exploitation
Systolic Blood Pressure (1)	110
Diastolic Blood Pressure (1)	60
Blood Pressure taken in which Position (1)	Sitting
Blood Pressure taken in which Ann (1)	Left
Activity Level at which Blood Pressure was taken (1)	At rest
Systolic Blood Pressure (2)	100
Diastolic Blood Pressure (2)	60
Blood Pressure taken in which Position (2)	Standing
Blood Pressure taken in which Arm (2)	Left
Activity Level at which Blood Pressure was taken (2)	At rest
Pulse (1)	78
Location Pulse was Taken (1)	2 - Radial
Characteristic of Pulse (1)	1 - Regular
Respirations	20
Oxygen Use	None
Temperature	97.6
Temperature Degrees measured in	Fahrenheit
Location Temperature was Taken	1 - Oral
Height in Feet	5
Inches	6
Weight in Pounds	195.6
Weight is	Actual
Neurological	2 - Oriented
Mental Assessment for Certification	1 - Oriented to person, place, time, and purpose.
Responsiveness	Alert Readily responds
Attention level	Normal
Short-term memory	Normal
Long-term memory	Normal
Judgement/Safety	Good
Awareness of deficits	Good
Eyes	WNL

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1612300367

Customer: 4 - Healthcare info... Customer ID: 00094066 Admit ID: 00046553

(M1200) VISION (with corrective lenses if the patient usually wears them)	0 - Normal vision: sees adequately in most situations; can see medication labels, newsprint.
Ears	WNL
Oral	WNL
(M1220) Understanding of Verbal Content in patients own language (with hearing aid device if used)	0 - Understands: clear comprehension without cues or repetitions.
(M1230) Speech and Oral (Verbal) Expression of Language (in patients own language)	0 - Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment.
Nose and Sinus	WNL
Neck and Throat	WNL
Pain	Yes
Location of Pain (1)	MIDLINE CHEST
Pain (1) Is	Acute
Pain intensity (1)	7
Pain Control Measures (1)	1 - Rest 4 - Medication 6 - Relaxation
Best Response to Control Measures (1)	2
Pain Expression Notes	A TIGHTNESS IN MY CHEST
What is pain preventing patient from doing	COUGHING - USES HEART PILLOW
How long does patients pain last	OFF AND ON
Is there a pattern to the pain	No
Is there a time of day when pain is worse	NO
Does the pain vary	Yes
Is the Physician	Aware
(M1240) Has the patient had a formal Pain Assessment using a standardized pain assessment tool?	1 - Yes, and it does not indicate severe pain
(M1242) Frequency of Pain Interfering with patients activity or movement	1 - Patient has pain that does not interfere with activity or movement
Skin Color	WNL
Skin Turgor	2 - Fair
Skin Temperature	1 - Warm
Skin Moisture	1 - Dry
Braden Scale Sensory Perception	No Impairment - Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.
Sensory Perception Score	4
Braden Scale Moisture	Rarely moist - Skin is usually dry; linen only requires changing at routine intervals.
Moisture Score	4
Braden Scale Activity	Walks frequently - Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.
Activity Score	4
Braden Scale Mobility	No limitations - Makes major and frequent changes in position without assistance.
Mobility Score	4
Braden Scale Nutrition	Adequate - Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs.

HH SN Start of Care (Visit 11/16/2010)

1512300367

Customer: 4 - Healthcare info... Customer ID: 00094065 Admit ID: 00046553

Nutrition Score	3
Braden Scale Friction and Shear	No apparent problem - Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.
Friction and Shear Score	3
Braden Scale Total Score	22
(M1300) Pressure Ulcer Assessment: Was this patient assessed for Risk of Developing Pressure Ulcers?	2 - Yes, using a standardized tool, e.g., Braden, Norton, other
(M1302) Does the patient have a Risk of Developing Pressure Ulcers?	0 - No
(M1306) Does this patient have at least one unhealed Pressure Ulcer Stage II or higher or designated as unstageable?	0 - No
(M1322) Current Number of Stage 1 Pressure Ulcers	0
(M1324) Stage of Most Problematic (Observable) Pressure Ulcer	NA - No observable pressure ulcer or unhealed pressure ulcer
(M1330) Does this patient have a Stasis Ulcer	0 - No
(M1340) Does this patient have a Surgical Wound?	1 - Yes, patient has at least one (observable) surgical wound
(M1342) Status of Most Problematic (Observable) Surgical Wound?	2 - Early/partial granulation
(M1350) Does this patient have a Skin Lesion or Open Wound, excluding bowel ostomy, other than those described above that is receiving intervention by the home health agency?	0 - No
Circulation	WNL
Heart Sounds	Regular
Peripheral Pulse	WNL
Edema	None noted
Vascular Access	NA
Respiratory Status	WNL
(M1400) When is the patient dyspneic/short of breath	0 - Patient is not short of breath
Breath Sounds	Clear bilaterally
Oxygen Saturation %	96
Productive Cough	0 - No
(M1410) Respiratory Treatments	4 - None of the above
Conditions Affecting Genitourinary Status	2 - Frequency
Urinary Catheter	0 - None
(M1600) Urinary Infection	0 - No
(M1610) Urinary Incontinence	0 - No incontinence or catheter (includes anuria or ostomy for urinary drainage)
(M1620) Bowel Incontinence Freq	0 - Very rarely or never has bowel incontinence
Conditions/Symptoms Affecting Ingestion/Digestion	5 - Heartburn/Reflux
Conditions Affecting Elimination	WNL
Date of Last Bowel Movement	11/15/2010
(M1630) Ostomy for Bowel Elimination	0 - Patient does not have an ostomy for bowel elimination
Abdominal Status	WNL
Bowel Sounds	WNL
Nutritional Requirements/Special Diet	2 - Low sodium/No salt added 8 - ADA diet No modification required
Diet Compliance	Compliant
Appetite	2 - Fair
Diet/Nutritional Status	WNL

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HH SN Start of Care (Visit 11/16/2010) 1512300367

Customer: 4 - Healthcare inf... Customer ID: 00094065 Admit ID: 00048553

Nutritional Risk Assessment	2 - Has an illness that changed the kind/amount of food eaten 1 - Eats alone most of the time
Total Nutritional Score (Refer to Legend For Results)	3
(M1700) Cognitive Functioning	0 - Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.
(M1710) When Confused	0 - Never
(M1720) When Anxious	0 - None of the time
(M1730) Depression Screening	1 - Yes, patient was screened using the PHQ-2c scale. (Instructions for this two-question tool: Ask patient: "Over the last two weeks, how often have you been bothered by any of the following problems") 0 0
(M1740) Cognitive, behavioral	7 - None of the above behaviors demonstrated.
(M1745) Frequency of Disruptive Behavior	0 - Never
(M1750) Receiving Psychiatric Nursing Services	0 - No
Musculoskeletal Status	NA
Coordination, Gait, Balance	NORMAL GAIT AND BALANCE
Functional Limitations	6 - Endurance
Activities Permitted	3 - Up as tolerated 7 - Independent at home
(M1800) Grooming	0 - Able to groom self unaided with or without the use of assistive devices or adapted methods.
Grooming Habits	1 - Neat
(M1810) Current Ability to dress upper body.	0 - Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.
(M1820) Cunent ability to dress lower body	2 - Someone must help the patient put on undergarments, slacks, socks or nylons and shoes.
(M1830) Bathing	3 - Able to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision
(M1840) Toilet Transferring	1 - When reminded, assisted or supervised by another person, able to get to and from the toilet and transfer.
(M1845) Toileting Hygiene	1 - Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient.
(M1850) Transferring	1 - Able to transfer with minimal human assistance or with use of an assistive device.
(M1860) Ambulation/Locomotion	2 - Requires use of a two-handed device (e.g., walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
(M1870) Feeding or Eating	0 - Able to independently feed self.
(M1880) Current Ability to Plan and Prepare	1 - Unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations.
(M1890) Ability to use telephone	0 - Able to dial numbers and answer calls appropriately and as desired.
(M1900) Prior Functioning ADL – a. Self-Care (e.g., grooming, dressing and bathing	0 - Independent
(M1900) Prior Functioning ADL – b. Ambulation	0 - Independent
(M1900) Prior Functioning ADL – c. Transfer	0 - Independent
(M1900) Prior Functioning ADL – d. Household tasks (e.g., light meal preparation, laundry, shopping	0 - Independent
Fall Risk Level of Consciousness/Mental Status	0 - Alert and oriented X3

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HH SN Start of Care (Visit 11/16/2010)

1612300367

Customer: 4 - Healthcare inf... Customer ID: 00094066 Admit ID: 00046553

Fall Risk Level of Consciousness/Mental Status Score	0
Fall Risk History of Falls (past 3 months)	2 - 1 - 2 falls
Fall Risk History of Falls (past 3 months) score	2
Fall Risk Ambulation/Elimination Status	0 - Ambulatory/continent
Fall Risk Ambulation/Elimination Status Score	0
Fall Risk Vision Status	0 - Adequate (w/ or w/o glasses)
Fall Risk Vision Status Score	0
Fall Risk Timed Up and Go	2 - Typical Mobility (10 to 19 seconds)
Fall Risk Timed Up and Go Score	2
Fall Risk Gait and Balance	0 - Normal/safe gait and balance while standing or walking
Fall Risk Gait and Balance Score	0
Fall Risk Orthostatic Changes	0 - No noted drop in blood pressure between lying and standing. No changes in cardiac rate
Fall Risk Orthostatic Changes Score	0
Fall Risk Medication	2 - Takes 1-2 of these medications currently and/or w/in past 7 days
Fall Risk Medication Score	2
Fall Risk Predisposing Disease	0 - None present
Fall Risk Predisposing Disease Score	0
Fall Risk Equipment Issues	0 - No risk factor noted
Fall Risk Equipment Issues Score	0
Fall Risk Total Score	6
(M1910) Multi Factor Falls Risk Assessment	1 - Yes, and it does not indicate a risk for falls.
Medication Compliance	1 - Compliant
Medication adverse effects/drug reaction	Non apparent/Patient denies
(M2000) Drug Regimen Review	1 - No problems found during review
(M2010) Patient Caregiver High Risk Drug Education	1 - Yes
(M2020) Management of Oral Medications	0 - Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.
(M2030) Management of Injectable Medications	NA - No injectable medications prescribed.
(M2040) Prior Medication Management -- a. Oral Medications	0 - Independent
(M2040) Prior Medication Management -- b. Injectable Medications	NA - Not Applicable
(M2100) a. ADL assistance (e.g., Transfer/ambulation, bathing, dressing, toileting, eating/feeding)	2 - Caregiver(s) need training / supportive services to provide
(M2100) b. IADL assistance (e.g., meals, housekeeping, laundry, telephone, shopping, finances)	1 - Caregiver(s) currently provides assistance
(M2100) c. Medical administration (e.g., oral, inhaled or injectable)	0 - No assistance needed in this area
(M2100) d. Medical procedures treatment (e.g., changing wound dressing)	1 - Caregiver(s) currently provides assistance
(M2100) e. Management of Equipment (includes oxygen, IV/infusion equipment, enteral / parenteral nutrition, ventilator therapy equipment or supplies)	0 - No Assistance needed in this area
(M2100) f. Supervision and safety (e.g., due to cognitive impairment)	1 - Caregiver(s) currently provides assistance
(M2100) g. Advocacy or facilitation of patients participation in appropriate medical care (includes transportation to or from appointments)	1 - Caregiver(s) currently provides assistance
(M2110) How often does the patient receive ADL or IADL assistance from any caregiver(s) (other than home health agency staff)?	1 - At least daily

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HH SN Start of Care (Visit 11/16/2010)

1512300367

Customer: 4 - Healthcare inf... Customer ID: 00094085 Admit ID: 00046553

Grab Bars [toilet/shower/tub] / (Assist Device)	Needs
Hand Held Shower (Assist Device)	Needs
Tub Transfer (Assist Device)	Needs
Wound (Specify)	NONE
Date influenza immunization given	09/16/2010
Influenza immunization given by	Other
Conditions Affecting the Endocrine System	Diabetes
Glucometer Reading	107
Home Monitoring Insulin given	0
Home Monitoring Notes	USUAL RANGE 103-130
Venipuncture	NA
Safety Measures	4 - Implement a falls prevention program (e.g., remove throw rugs, teach safe use of assist/safety devices) 9 - Teach standard precautions (e.g., handwashing, safe disposal of contaminated sharps and supplies)
Can the patient understand verbal instructions?	1 - Yes
Can the patient read and understand simple written instructions?	1 - Yes
Client/Caregiver prefers to learn through:	Combination
Client/Caregiver is aware of financial implications of their choices?	1 - Yes
Instructions/Materials Patient Bill of Rights	1 - Patient Bill of Rights/Responsibilities
Instructions/Materials Patient Bill of Rights - Discussed	Discussed
Instructions/Materials Patient Bill of Rights - Copy left in home	Copy left in home
Instructions/Materials State home health hotline number	2 - State home health hot line number
Instructions/Materials State home health hotline number - Discussed	Discussed
Instructions/Materials State home health hotline number - Copy left in home	Copy left in home
Instructions/Materials Verification of benefits	3 - Verification of benefits
Instructions/Materials Verification of benefits - Discussed	Discussed
Instructions/Materials Verification of benefits - Copy left in home	Copy left in home
Instructions/Materials Advance Directives	4 - Advance Directives
Instructions/Materials Advance Directives - Discussed	Discussed
Instructions/Materials Advance Directives - Copy left in home	Copy left in home
Instructions/Materials Home care service agreement	5 - Home care service agreement
Instructions/Materials Home care service agreement - Discussed	Discussed
Instructions/Materials Home care service agreement - Copy left in home	Copy left in home
Instructions/Materials Home health visit schedule	6 - Home health visit schedule
Instructions/Materials Home health visit schedule - Discussed	Discussed
Instructions/Materials Home health visit schedule - Copy left in home	Copy left in home
Materials Given to	Patient
(M2200) Therapy Need Number of visits	004
(M2200) Refer to ST	ST
(M1032) Taking five or more medicines	4 - Taking five or more medications
Prognosis	4 - Good

HH SN Start of Care (Visit 11/16/2010)

1612300367

Customer: 4 - Healthcare inf... **Customer ID:** 00094065 **Admit ID:** 00046553

(M1034) Overall Status	1 - The patient is temporarily facing high health risk(s) but is likely to return to being stable without heightened risk(s) for serious complications and death (beyond those typical for the patient's age).
Rehabilitation potential (Plan of Care - 22)	2 - Good
Follow up appointments	1 - Yes
Appointment with	dR qUINTON
Contact Information	12-22
(M2250) Plan of Care Synopsis – a. Patient-specific parameters for notifying physician of changes in vital signs or other clinical findings	1 - Yes
(M2250) Plan of Care Synopsis – b. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	0 - No
(M2250) Plan of Care Synopsis – c. Falls prevention interventions	0 - No
(M2250) Plan of Care Synopsis – d. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	NA - Not Applicable
(M2250) Plan of Care Synopsis – e. Intervention(s) to monitor and mitigate pain	1 - Yes
(M2250) Plan of Care Synopsis – f. Intervention(s) to prevent pressure ulcers	NA - Not Applicable
(M2250) Plan of Care Synopsis – g. Pressure ulcer treatment based on principles of moist wound healing OR order for treatment based on moist wound healing has been requested from physician	NA - Not Applicable

Inician Diagnoses

Resolved	Description
	SN V3 Admission Guideline
	SN V3 Standard Visit Guideline
	SN Altered Comfort
	WD V3 Surgical Wounds
	SN Altered Cardiovascular Function (Angina, CAD, AFib, MI, HTN, PVD)

Clinical Note

74 YEAR OLD FEMALE ADMITTED TO HOME HEALTH FOLLOWING SURGERY FOR AORTIC STENOSIS AND AORTIC VALVE REPLACEMENT/SHE LIVES ALONE IN A TWO-STORY CONDO BUT MAINLY LIVES ON THE UPPER LEVEL/SHE HAS TWO SONS AND THEIR WIVES WHO ARE HELPING OUT 24/7 FOR NOW/SHE HAS H/O NIDDM AND IS WELL CONTROLLED WITH CURRENT THERAPY WITH BS RANGING 103-130 AND CHECKS HER BS AT LEAST DAILY/SHE HAS A MID-LINE CHEST INCISION CLOSED WITH SURGICAL GLUE AND IS APPROXIMATED/NO DRAINAGE/NO S/SX OF INFECTION/NO DRESSING IS NEEDED/SHE USES HER HEART PILLOW FOR SUPPORT/SHE IS ALERT/FRIENDLY AND VERY CHATTY/PAIN IS MANAGED WELL WITH 3-4 VICODIN Q DAY AND THIS HAS BEEN EFFECTIVE/BOWEL PROTOCOL WAS REVIEWED AND SHE REPORT ONLY A SMALL BM YESTERDAY/INSTRUCTION PROVIDED TO TRY A OTC STOOL SOFTENER/INCREASE PO FLUID AS TOL/ADD FIBER TO DIET AND USE OF MOM THAT SHE HAS USED IN THE PAST/BT'S + TO ALL QUADS/URINE WITHOUT PROBLEM/NO SKIN ISSUES EXCEPT FOR SOME SCATTERED BRUISING ON HER ARM/SHE REPORTS FALLING IN THE BR AT THE HOSPITAL AND HAS A BRUISE ON HER LT FOREHEAD THAT IS LIGHTENING - SHE REPORTS THEY TOLD HER SHE GOT UP TOO FAST/SHE IS NOW STANDING BY HER RECLINER FOR

HH SN Start of Care (Visit 11/16/2010) 1512300367

Customer: 4 - Healthcare in... Customer ID: 00094065 Admit ID: 00046553

A MINUTE OR SO AND POSTURALS WERE 110/60 SITTING AND 100/60 STANDING/LUNGS ARE CLEAR AND SATS AT REST WAS 98% AT REST AND 96% WITH 10'FT AMBULATION/HEART RATE WNL AT 78 AT REST AND 84 WITH 10' AMBULATION/WEIGHT TODAY WAS 195.7 AND SHE WAS INSTRUCTED TO REPORT A 2LB WEIGHT GAIN IN ONE DAY AND SHE VOICED UNDERSTANDING/AM REQUESTING OT FOR BR SAFETY AS TUB IS QUITE HIGH AND THERE WERE NO GRAB BARS/SHE IS LOOKING INTO CHANGING OUT TO A SHOWER "LATER"/REVIEWED POC/TOL SNV WELL/JA

Plan For Next Visit

POSTURALS BP/WEIGHT/INCISION/HOME AND MED MANAGEMENT

Created: 11/16/2010 5:00:00PM **Printed:** 12/1/2010 1:43:14PM
Completed:
Author: Alspaugh, Joan M RN
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11/15/10

How's 4 - Healthcare inform...?

915 7733

Mother Joseph
493-4900

Pt is Home = Doing Very Well RE: Daughter N Law

THANKS! – Doing good
visiting nurse
2 x week
following up c
cardiologist. 11.17.10
JB NAS

PLEASE CALL AGAIN on WEDNESDAY

~~ST PETER~~ SOUND
HOME CARE
459-8311

KADIAN®
Morphine Sulfate Extended-Release Capsules
10mg • 20mg • 30mg • 50mg • 60mg • 80mg • 100mg • 200mg

SHAWN: SOM 486-4286

10 mg 20 mg 30 mg 50 mg 60 mg 80 mg 100 mg 200 mg

Capsules are not shown at actual size

Please see accompanying complete Prescribing Information.

Olympia Cardiac Surgery, Inc., P.S.

CARDIAC, THORACIC, AND VASCULAR SURGERY

525 Lilly Rd. NE Suite 200 Olympia WA 98506
(360) 493-4510

November 15, 2010

Dr. W. Kirk Harris
6981 Littlerock Road #101
Tumwater, WA 98512

Re: [redacted] 4 - Healthcare i...

Dear Dr. Harris:

4 - Healthcare information readily ..., 74, was discharged from St. Peter Hospital on November 13, 2010 following an aortic valve replacement through an upper mini sternotomy using a 21-MM MEDTRONIC Hancock II T505 cinch porcine bioprosthesis on November 10th, 2010. She was in CICU for one day then transferred to PCU for the remainder of her care.

Her postoperative course was complicated by atrial fibrillation which converted to normal sinus rhythm with medical therapy. On discharge her sternum is stable and her incisions are healing well. I will see her in my office in four weeks for a follow up visit. Please see attached discharge medication sheet for medications.

When discharged from St. Peter Hospital her HCT was 29.0.

You will receive a copy of her operative report and the discharge summary under separate cover from St. Peter Hospital. Thank you for the opportunity to participate in the care of Mrs. Tuitele.

Sincerely,

Ronald R. Quinton, M.D., F.A.C.S.

RQ/da

RONALD R. QUINTON, M.D., F.A.C.S.
Diplomate, American Board of Surgery
Diplomate, American Board of Thoracic Surgery

MARINA V. BERNDT, P.A.C.

LUIS F. SANTAMARINA, M.D.
Diplomate, American Board of Surgery
Diplomate, American Board of Thoracic Surgery

After completing this form make a copy for the patient, fax a copy to Dr Quinton and Dr. Santamarina's office 493-7759, and place original in the chart.

6DIN

Admission Weight: 85 kg Discharge Weight: 91 kg

Hematocrit: 29 % INR: _____ Creatinine: _____

MEDICATIONS TO BE TAKEN AT HOME:

MEDICATION / STRENGTH	DIRECTIONS FOR USE	LAST DOSE TAKEN
1. Enteric Coated Aspirin (Ecotrin®) ☐ 81 mg ☑ 325 mg	1 tablet by mouth daily	— 0 ✓
2. Hydrocodone 5mg / Acetaminophen ~~500~~ 325mg (Vicodin®)	1-2 tablets by mouth every 4 hrs as needed for pain	— 0 6hrs pm
3. Metoprolol (Lopressor®) 25mg	1 tablet by mouth twice a day for 4 weeks	✓ 0 ✓
4. Famotidine (Pepcid®) 20mg	1 tablet by mouth twice a day for 2 weeks	Gone -
5. Simvastatin (Zocor®) ~~40mg~~ 20mg	1 tablet by mouth daily in the evening	✓ 0 ✓
~~6. Isosorbide Mononitrate (Imdur®) 30mg~~	~~1 tablet by mouth a daily for 6 weeks~~	
~~7. Lisinopril (Prinivil/Zestril®) 10mg~~	~~1 tablet by mouth daily~~	
~~8. Digoxin (Lanoxin® Digitek®) 0.125mg~~	~~1 tablet by mouth daiiy for 4 weeks~~	
9. Amiodarone (Pacerone®) 200mg	1 tablet by mouth ~~twice~~ once a day for ~~2 weeks~~ 4 weeks	✓ 0 dly
10. Furosemide (Lasix®) 40mg	1 tablet by mouth 1/2 times a day 4 weeks	✓ 0 ✓
11. Potassium Chloride 10mEq	1 tablet by mouth 1/2 times a day 4 weeks	✓ Gone dly
12. fluoxetine 40mg	1 a day	✓ 0 ✓
13. metformin 500mg	1 twice a day	✓ 0 ✓
14. Lorazepam	at bedtime prn sleep	✓
15.		
16.		
17.		
18.	6 Apr	
19.	3 Nights	
20.		

See attached

Please, do not take any other medications without asking your surgeon.

SEE THE BACK OF THIS PAGE FOR FURTHER DISCHARGE INSTRUCTIONS

PROVIDENCE St. Peter Hospital

DISCHARGE INSTRUCTIONS: CARDIAC SURGERY PATIENT

Form Number: 6031-30-NH-01 FCC: 10/23/08

Patient Identification:

4 - Healthcare informatio...
DOB 4 - Health... 74Y F MR: 0001-07-97-75
ACCT: 10306-00302 DOS: 11/10/10

MD 2011-157968-000167

12:30PM
12/1/10

DIET INSTRUCTIONS: ☑ Low Fat / Low Salt ☑ Carb Controlled ☐ Total Fluids

ACTIVITIES:
1. Shower daily
2. Walk 4 times a day as you tolerate.
3. Do not drive for 3 weeks.
4. Do not lift greater than 10 lbs for 6 weeks.

OTHER INSTRUCTIONS:
1. Have two view chest X-ray (CXR) done the day before or day of first post operative visit, with ☑ Dr. Quinton ☐ Dr. Santamarina. **Bring films to appointment.**
2. Have protrombin test done on Date: ___/___/___ and report the result to _____
3. Have EKG done for your 1st appointment with ☐ Dr Quinton ☐ Dr Santamarina
4. daily weight- next dyne wt
5. _____
6. _____

FOLLOW-UP:
1. After discharge, call your Cardiac Surgeon Dr. Quinton / Dr. Santamarina ASAP for 12/22 2pm your 4 week appointment. Phone # 360-493-4510
2. After discharge, call your Cardiologist Dr. Brenan for your 2 week appointment. Phone # 413 9525

Call your Heart Surgeon if you experience:
- Persistent nausea or vomiting
- Drainage / bleeding at the surgical site
- Weight gain of 2 or more pounds in one day
- Fever, chills, increased pain that is not relieved by pain medications
- Difficulty breathing, unusual shortness of breath
- Others listed in your heart surgery instruction folder
- Frequent coughing or cough spells
- Other: _____

SMOKING CESSATION (For Smokers Only):
If you use tobacco, or have used tobacco in the past twelve months, it is very important that you stop now. For help in quitting tobacco, review the **Smoking Cessation Information** packet, and / or call the Washington State Quit Line at 1-877-270-7867.

Patient / Family verbalized understanding ☐ **YES** ☐ **NO** or demonstrated ability ☐ **YES** ☐ **NO** of home care

Patient / Family Member Signature: _____ **Date:** ___/___/___ **Time:** _____

Physician / Nurse Signature: _____ **Date:** ___/___/___ **Time:** _____

DISCHARGE INSTRUCTIONS:
CARDIAC SURGERY PATIENT
Form Number: 6031-30-NH-01 FCC: 10/23/08

4 - Healthcare informatio...
DOB: 4 - Health... 74Y F MR:0001-07-97-75
ACCT: 10306-00302 DOS: 11/10/10

(This information may be protected by Federal and/or State Law prohibiting further disclosure.)

Admit Date: 11/10/2010
Discharge Date: 11/13/2010

DATE OF ADMISSION: 11/10/2010.

DATE OF DISCHARGE: 11/13/2010.

HISTORY OF PRESENT ILLNESS AND COURSE: The patient is a 74-year-old Scottish female admitted with symptomatic critical aortic stenosis. She was taken to the operating room on the day of admission, and underwent an aortic valve replacement through a minimally invasive upper mini sternotomy incision. Her valve was replaced with a Medtronic Hancock II Ultra 21 mm stented bioprosthetic. Postoperatively, the patient has done well. She did develop atrial fibrillation which converted to sinus rhythm with medical therapy. At the time of discharge, she is ambulating 360 feet and able to get out of the bed and chair without problems. Her incisions are healing without evidence of infection or drainage. Discharge weight is 91.5 kg with preoperative weight of 85 kg. Last hematocrit was 29.

FINAL DIAGNOSES:
1. Aortic stenosis.
2. Atrial fibrillation postoperatively.
3. Hypertension.
4. Hypercholesterolemia.
5. Non-insulin dependent diabetes mellitus.
6. Chronic kidney disease stage 3.

PROCEDURES PERFORMED: Minimally invasive upper mini sternotomy with aortic valve replacement.

DISCHARGE MEDICATIONS: Enteric-coated aspirin 325 mg a day, Vicodin 5/325 mg p.o. q. 4 hours p.r.n. pain. Metoprolol 25 mg p.o. b.i.d. for 4 weeks, famotidine 20 mg p.o. b.i.d. for 2 weeks, simvastatin 40 mg q.p.m., amiodarone 200 mg p.o. b.i.d. for 4 weeks, furosemide 40 mg a day for 4 weeks, potassium chloride 10 mEq a day for 4 weeks, fluoxetine 40 mg daily, metformin 500 mg p.o. b.i.d., lorazepam as used preoperatively. Hydrochlorothiazide 25 mg, the patient to start this when her Lasix is done in 1 month.

ACTIVITIES: Patient may participate in cardiac rehab. The patient not to lift greater than 10 pounds for 6 weeks. Patient not to drive for 3 weeks.

DIET: No added salt, low salt, low cholesterol, low fat, carb controlled diet.

FOLLOWUP: The patient to see Dr. Brennan in approximately 2 weeks. Patient to see Dr. Quinton in 4 weeks.

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PROVIDENCE ST. PETER HOSPITAL
Olympia, Washington

(This information may be protected by Federal and/or State Law prohibiting further disclosure.)

Admit Date: 11/10/2010

DATE OF OPERATION: 11/10/2010

DATE OF OPERATION: 11/10/2010

PREOPERATIVE DIAGNOSIS: Critical aortic stenosis.

POSTOPERATIVE DIAGNOSIS: Critical aortic stenosis.

OPERATION PERFORMED: Aortic valve replacement through an upper mini sternotomy incision.

SURGEON: Ronald Quinton, MD

ASSISTANT: Ken Eder, RNFA

ANESTHESIA: General endotracheal anesthesia with extracorporeal circulation.

ANESTHESIOLOGIST: Telfer Griffith, MD

PERFUSIONIST: Mr. Wilken

SPONGE AND NEEDLE COUNTS: Reported correct.

DRAINS: 2 Blake drains and a Foley catheter.

FINDINGS: Only the aorta and aortic valve could be visualized. The aorta was somewhat small in diameter but otherwise normal quality. Aortic valve was tricuspid. It had calcific stenosis. Aortic valves placed with a Medtronic Hancock II Ultra 21 mm porcine bioprosthetic stented valve. Postprocedure TEE demonstrated good prosthetic valve function.

SURGICAL PROCEDURE: The patient was brought the operating room, placed in a supine position. After adequate general anesthesia was obtained, the patient was prepped and draped in the usual sterile fashion. A minimally invasive upper mini sternotomy incision was made. The sternum was divided down to the third intercostal space then J'd to the right. The patient was heparinized. The sternum was spread and the mediastinal fat divided. The pericardium was opened and suspended. Heart was cannulated with an aortic inflow cannula through the distal ascending aorta and 2-stage venous uptake cannula through the right atrial appendage. The patient was placed on normothermic extracorporeal circulation. An antegrade cardioplegic catheter was placed. Aortic crossclamp was then placed. The heart was given cold blood potassium cardioplegic solution, first antegrade and then directly into the coronary ostia after we opened the aorta. The left ventricular sump was placed to the right superior pulmonary vein. The aorta was opened transversely at the sinotubular jmction. The aorta was quite small at the sinotubular junction. I had to extend the incision down into the noncoronary sinus in a J fashion to be able to get a sizer in. The

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aortic valve was excised and the annulus decalcified. The new valve was seated using interrupted horizontal mattress sutures of 2-0 Ethibond with pledgets on the ventricular side of the annulus. The aortotomy was then closed with running 4-0 Prolene suture in a double layer. The patient was placed in Trendelenburg position. The heart was given a warm shot of cardioplegic solution and warm blood. There was some leakage around the closure part of the noncoronary sinus. This was reinforced with pledgeted 4-0 sutures. At completion of the cardioplegia, warm blood, the cross-clamp was removed. Heart came back in a slow junctional rhythm. We did place a ventricular wire and paced for part of the case. The wire was removed at the end of the case as she was in her own sinus rhythm at 75. The patient given protamine. After adequate hemostasis obtained, a Blake drain was placed in the pericardium, brought out through the left side of the neck. The pericardium was closed. Another drain was placed in the anterior mediastinum with the tail going into the right pleural space. The chest was irrigated with antibiotic solution. Bilateral Marcaine pericostal blocks were performed. The sternum was closed with interrupted wires. The fascia and skin were closed with running absorbable sutures. The wounds were dressed sterile occlusive dressings. The patient was then transported to the CICU in stable condition.

Ronald R Quinton, MD

Job#: 26097457 D: Wed Nov 10 14:43:30 2010 EST T: Wed Nov 10 15:33:52 2010 EST
DOB: 4 - Healthcare info... MLS#: 97674
cc: William P Brennan, MD; Kirk W Harris, MD

Adm. Date: **11/10/2010** Ronald R Quinton, MD
Room#: CC05 1 Age: 74 MR: 0001079775
PATIENT: 4 - Healthcare information readil... PT: 1030600302

OPERATIVE REPORT

COPY for Kirk W Harris, MD

William P. Brennan, M.D.
Roger S. Chan, M.D.
William A. Gavin, M.D.
Richard P. Kennedy, M.D.
Qiang Li, M.D.

Cardiology Associates, PLLC

David H. Schoening, M.D.
Robert S. Wark, M.D.
Craig J. Wehrli, M.D.
Christopher L. Wolfe, M.D.
Willa Nizolek, B.S.N., M.B.A.

November 2, 2010

W Kirk Harris, MD
6981 Littlerock Road, #101
Tumwater, WA 98512

4 - Healthcare information readily identif...
143-249-508
4 - Healthcare i...

Dear Kirk,

Today I performed angiography oh 4 - Healthcare inform... . As you recall, 4 - Heal... came to the office for Lexiscan Myoview study and had marked chest pain with Lexiscan infusion. For that reason I saw her on consultation and because of her impressive history of angina, proceed on to angiography today. She also had a noted murmur so we performed right and left heart catheterization.

The study demonstrated significant aortic stenosis with a mean gradient of 41 mmHg and a valve area of 0.6 cm2. Her coronary arteries were normal and her left ventricular function was normal.

Thus, I believe 4 - Healt...'s symptoms are on the basis of her aortic valve disease. She will be seen today by Olympia Cardiac Surgery with the arrangements to be made for aortic valve replacement.

Again, it was a pleasure to assist in 4 - Healt...'s care. A copy of her consult note and catheterization report should be coming to you directly from St. Peter Hospital.

Sincerely,

William P. Brennan

William P Brennan MD

[Created: WILLIAM P BRENNAN MD on 11/02/2010 at]
[Transcribed: mj on 11/05/2010 at 08:24 AM]
[Approved: JESSICA JOHNSON_MA for BRENNAN, WILLIAM P MD on 11/05/2010 at 10:01:57 AM]
[Finalized: 11/05/2010 at 10:01:57 AM]
cc.

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NOV 15 2010

WKH

4 - Healthcare inform...

11/9/10

Please give 4 - H... e a call and see how she is doing.

I'm glad they found her heart valve problem.

Has she already gone for the surgery to open up her constricted valve?

WKHpc

11/9/10 Very upset c Dr Harris. Has been c/o of these s/s for a long time. felt like he did Nothing open Heart Surg on 11/10/10 @ 5:30 Am Dr Quintessa.

PHONE MEMO

TO Dr. Harris | DATE | TIME Message AM PM

FROM Cardiology Nurse - OUT | PHONE 4 - Healthcare information readily identifi... | CELL ( ) | Fax ( )

OF Pat - Dr. Brennan TALKED W/ PAT AT LENGTH ABOUT JOYCE 11-9-10

MESSAGE

Dr. Brennan would like to speak w/ you re: 4 - Healthcare informati... 6 - Identity - Whistleblow...

TALKED AT LENGTH W/ Dr. Brennan

E-MAIL ADDRESS + Joyce 2pm - 3pm. | SIGNED

PHONED | CALL BACK | RETURNED CALL | WANTS TO SEE YOU | WILL CALL AGAIN | WAS IN | URGENT

ARICEPT® (donepezil HCl) 5-MG AND 10-MG TABLETS He's Going to Get a Lawyers 'Letter from Her', Dr. Brennan felt all the S/S came from this problem

ARICEPT® (donepezil HCl) 5-MG AND 10-MG TABLETS

Greg (Son)
707-628-3493

CHF
SOB
SYNCOPE
CP

WOULD NOT HAVE DONE ANYTHING DIFFERENT UNTIL SHE BECAME SYMPTOMATIC

PROVIDENCE ST. PETER HOSPITAL
Olympia, Washington

(This information may be protected by Federal and/or State Law prohibiting further disclosure.)

Admit Date: 11/02/2010

DATE OF CONSULTATION: 11/02/2010

TO:

CONSULTATION DATE: 11/02/2010

SUBJECTIVE: The patient is a 74-year-old Scottish female who has had progressive chest pressure, some pain, some dyspnea on exertion and increasing tiredness. She is found to have critical aortic stenosis. I have been asked to see the patient for consideration for aortic valve replacement. The patient has been told in the past she had a murmur of aortic stenosis but had been asymptomatic. She has had some lightheaded spells but no blackout spells. She denies any history of ischemic heart disease or arrhythmias or admissions for congestive heart failure. She is now able to walk approximately 100 feet without getting short of breath, consistent with XXXXXXXXXX Heart Association functional class II heart failure which would be chronic systolic.

PAST MEDICAL HISTORY: Hypertension, hypercholesterolemia, non-insulin dependent diabetes mellitus, recently diagnosed. Chronic kidney disease stage 3 which developed after her hip surgery in 2004.

PAST SURGICAL HISTORY: She has had bilateral hip replacements.

ALLERGIES: Codeine makes her feel ill.

MEDICATIONS: Aspirin 325 mg a day, fluoxetine 40 mg q.a.m., lorazepam 50 mg q.a.m., hydrochlorothiazide 25 mg a day, Lanoxin 0.25 mg a day, metformin 500 mg b.i.d., simvastatin 40 mg a day.

HABITS: Tobacco: None. Alcohol: None.

SOCIAL HISTORY: The patient is widowed. She does have 2 sons in the area for support.

REVIEW OF SYSTEMS: Those symptoms noted in the present illness otherwise the patient has a negative review of systems. I have nothing to add to Dr. Brennan's history and physical.

PHYSICAL EXAMINATION: GENERAL: The patient is a healthy-appearing, well-developed, well-nourished 74-year-old female in no acute distress. **VITAL SIGNS:** Normal. **HEENT:** No bruits. No JVD. No scleral icterus. **CHEST:** Symmetrical. **BREASTS:** Not examined. **LUNGS:** Clear to auscultation. **HEART:** Regular rate and rhythm with a 3/4 systolic murmur at the left upper sternal border. **ABDOMEN:** Soft, no tenderness, no pulsatile masses. **EXTREMITIES:** Show full range of

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COPY for Kirk W Harris, MD

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motion without clubbing, cyanosis, edema. **NEUROLOGIC:** Peripheral reflexes are intact. **SKIN:** No rashes or lesions.

DIAGNOSTIC STUDIES: EKG demonstrates normal sinus rhythm, left ventricular hypertrophy.

Her hematocrit was normal at 41, platelet counts normal. Her creatinine is elevated at 1.51 with a peak of 1.57 back in May. Her GFR was 34. Electrolytes are normal.

Chest x-ray really has no significant abnormalities.

Cardiac cath: I do not have a dictated report but from my review of the films and Dr. Brennan's note she was found to have normal coronary arteries. Normal left ventricular function. She had an aortic valve gradient of 43 mean. The aortic valve area is not calculated on the note.

ASSESSMENT: A 74-year-old with severe to critical aortic stenosis becoming progressively symptomatic. At this point, she would benefit from surgical replacement of aortic valve. I have discussed the diagnosis and planned procedure with the patient including the expected benefits, usual risks and alternatives. We discussed use of a tissue valve versus a mechanical valve with their advantages and disadvantages and my recommendation for a tissue valve. The patient states she understands and wishes to proceed. We will need to wait 4 days to rule out contrast-induced nephropathy, given her baseline chronic kidney disease. I have, therefore, scheduled her for November 10, 2010.

PLAN: The patient will be scheduled for surgery on November 10, 2010. Routine preoperative preparation done prior to that time.

Thanks for allowing me to participate in her care.

Ronald R Quinton, MD

Job#: 25872904 D: Tue Nov 02 14:57:23 2010 EST T: Tue Nov 02 15:30:43 2010 EST
DOB: 4 - Healthcare infor... MLS#: 97906
cc: Kirk W Harris, MD; William P Brennan MD

Adm. Date: **11/02/2010** Ronald R Quinton, MD
Room#: Age: 74 MR: 0001079775
PATIENT: 4 - Healthcare information readil... PT: 1030600038

CONSULTATION

COPY for Kirk W Harris, MD

William P. Brennan, M.D.
Roger S. Chan, M.D.
William A. Gavin, M.D.
Richard P. Kennedy, M.D.
Qiang Li, M.D.

Cardiology Associates, PLLC

David H. Schoening, M.D.
Robert S. Wark, M.D.
Craig J. Wehrli, M.D.
Christopher L. Wolfe, M.D.
Willa Nizolek, B.S.N., M.B.A.

CONSULTATION
October 29, 2010

W Kirk Harris, MD
6981 Littlerock Road, #101
Tumwater, WA 98512

4 - Healthcare information readily identif...
143-249-508
4 - Healthcare i...

REFERRING PHYSICIAN: W Kirk Harris MD

REASON FOR VISIT:
Chest Pressure/Tightness
DM Non-Insulin Controlled
Hypertension Controlled
Hypercholesterolemia

HPI:
4 - Healthcare inform... is a 74 -year-old female i am asked to see because of chest pain, dyspnea and abnormal Lexiscan Myoview study.

The patient has had several months of chest pain. She describes her status post as a substernal tightness without radiation. It is progressed to occurring a couple of times a day. She describes it as moderate and at other times severe. It can last up to ten minutes. This is specifically brought on by exertion such as walking and is relieved with rest. It is associated with dyspnea. She has had the pain at rest without any activity.

In addition, the patient complains of increasing problems with dyspnea. She states she can walk maybe 100 feet and then has to stop and breathe hard before she can go any further. She has had no orthopnea or paroxysmal nocturnal dyspnea or peripheral edema. She has had palpitations but no sustained racing of her heart. She has had no lightheadedness, syncope or near-syncope. She does have a history of a heart murmur.

RISK FACTORS:
Positive for hypertension, diabetes, hypercholesterolemia and family history of coronary artery disease. This is negative for smoking.

PAST MEDICAL HISTORY:
SURGERIES –
Right ear surgery, remote.
Bilateral hip replacement in 2001 and 2004
ILLNESSES –
Tuberculosis, remote
Type-2 diabetes.
Hypertension.
Hypercholesterolemia
HABITS – The patient denies alcohol abuse.

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CURRENT MEDICATIONS:

FLUOXETINE CAP 40mg 1 CAP PO QDAY in the morning
FLURAZEPAM CAP 15mg 1 CAP PO QDAY
HYDROCHLOROTHIAZIDE TAB 25mg 1 TAB PO QDAY
INDOMETHACIN CAP 25mg 1 CAP PO TID WITH FOOD
LANOXIN TAB 0.250mg 1 TAB PO QDAY
METFORMIN TAB 500mg 1 TAB PO BID with morning and evening meals
SIMVASTATIN TAB 40mg 1 TAB PO QDAY in the evening

Allergies and Intolerances—No known drug allergies.

SOCIAL HISTORY:
The patient is a widow with two sons. She lives at home. She is not currently working.

REVIEW OF SYSTEMS:
General- The patient reports fatigue, recent weight loss and sweats, but denies fevers or chills. Skin- No rashes. HEENT- The patient reports dizziness and hearing problems, but denies headaches or vision problems. Lungs- The patient reports orthopnea and DOE, but denies PND or wheezing. Heart- The patient reports chest pressure, heart murmurs and palpitations, but denies chest pain or heart murmur. GI- The patient reports loss of appetite, but denies bleeding from bowels, constipation, diarrhea, heart burn or indigestion. GU- No burning with urination, frequent urination or incontinence. Extremities- The patient reports arthritis, but denies ankle swelling or difficulty walking. Neuro- The patient reports difficulty with coordination and forgetfulness, but denies numbness or seizures. Psych- The patient reports anxiety and depression.

HABITS:
Tobacco- Never

PHYSICAL EXAMINATION:
VITALS- BP 190/90 Pulse 108 (Initial LA Sitting Large Cuff), Weight 190 lbs, Height 63 inches
CONSTITUTIONAL- The patient is well-appearing and is in no acute distress.
NECK- No significant JVD. No adenopathy.
CHEST- Grossly normal.
LUNGS- Clear to auscultation.
HEART
RHYTHM- Rhythm is regular.
PALPATION- PMI is within the MCL.
VALVES- S1 and S2 are normal.
GALLOPS- There is no S3 or S4.
AORTIC VALVE- Normal.
MITRAL VALVE- Normal.
ABDOMEN- Benign without hepatomegaly or splenomegaly.
EXTREMITIES- No clubbing, cyanosis or edema.
NEURO- Grossly intact.
PSYCH- Nonfocal and oriented to time and place without mood disturbance.

LIPID PROFILES:

	02/19/2009	05/27/2010	09/21/2010
CHOLESTEROL	-	-	-

HDL	-	-	-
LDL	-	-	-
SGOT	22	25	25
SGPT	19	24	25
TRIGLYCERIDES	-	-	-

Resting electrocardiogram demonstrates normal sinus rhythm with ST segment depression in V3 – V6; cannot exclude anterior ischemia.

With the Lexiscan Myoview the patient developed reproduction of her chest pain and had further decrease from 1 to 2-3 mm of ST segment depression in the same leads. Her stress images did show an apical defect as well as a septal defect. Resting images are pending. However, because of her history, we went ahead and saw her in consultation today.

IMPRESSION:

1. Rule out coronary artery disease characterized by;
   a. Class-3 limiting effort angina and dyspnea;
   b. Positive Myoview with ST segment depression and chest pain with Lexiscan effusion images pending;
   c. Resting anterolateral ST segment depression.
2. Diabetes mellitus, type-2.
3. Hypertension.
4. Hypercholesterolemia.

PLAN:

1. Discontinue INDOMETHACIN CAP 25mg 1 CAP PO TID WITH FOOD.
2. Start ASA 325mg 1 TAB PO QDAY.
3. Start NITROGLYCERIN SUBLINGUAL TAB 0.4mg Place 1 TAB SL at the 1st sign of an attack - may repeat every 5 min until relief up to a maximum of 3 doses.
4. Right & Left Heart Catheterization +/- Intervention at SPH-- The patient has been fully advised concerning the alternatives, benefits and risks of cardiac cath including, but not limited to, the risk of MI, vascular injury, CVA and death. The patient has also been consented for the potential of coronary intervention (including PTCA, coronary atherectomy or coronary stenting) as well as the potential risk of emergent CABG and of restenosis requiring secondary procedures. The patient gives informed consent and wishes to proceed. The procedure will be scheduled for (428.1 and 786.51) next week.
5. Basic Metabolic Panel (414.01) today.
6. Chest, 2 view (786.51) today.

We will set the patient up for right and left heart catheterization. We will evaluate her murmur and make sure she does not have aortic stenosis. We will keep dye load to a minimum because of her elevated creatinine in the past. We will check her creatinine today.

William P. Brennan

William P Brennan MD

[Created: WILLIAM P BRENNAN MD on 10/29/2010 at 01:03 PM]
[Transcribed: mj on 10/29/2010 at 03:38 PM]

Cardiology Associates, PLLC

MAIN OFFICE 500 N Lilly Rd. Olympia, WA 98506 Phone. (360) 413-8525 Fax. (360) 413-8837

ETT- CHEMICAL NUCLEAR
NUCLEAR MEDICINE, CA
10/29/2010

4 - Healthcare information readil...
143-249-508
4 - Healthcare i...

REFERRING PHYSICIAN: W Kirk Harris MD

CHEMICAL NUCLEAR DATA:

CPT * :	Myocardial Perfusion (78452) Stress Test (93015)	Stress Indications * :	Dyspnea (786.05)
Gender:	Female	Protocol:	Lexiscan 2 Day
Age:	74 yrs	Duration:	4 mins 0 secs
Height:	63 inches	Peak HR:	120 bpm
Weight:	170 lbs	Peak BP:	105 / 82
		Pharm Agent1:	Lexiscan IV
Resting HR:	94	Pharm Agent Dose1:	0.4 mg
Resting BP:	163 / 81	Pharm Agent2:	
LVEF:	%	Pharm Agent Dose2:	
Isotope Rest Name:	Myoview IV	Isotope Stress Name:	Myoview IV
Isotope Rest Dose:		Isotope Stress Dose:	31.4 mCi

ECG REST: Anterior ST depression. Lateral ST depression. Normal sinus rhythm.

ECG STRESS: 2.0 mm down-sloping ST depression in the lateral leads during stress test. More pronounced then at rest where it is approx. 1mmHg depressed.

NUCLEAR FINDINGS: The stress images are within normal limits. The attenuation corrected images are also within normal limits. There is no rest images available.

CONCLUSIONS: 1. Normal stress images. Rest images are not available. Therefore, most likely this is a normal myocardial perfusion stress test, except possible transient cavitary dilatation.

INTERPRETED BY: Qiang Li, MD

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NOV - 8 2010
WKH

[Created: NUCLEAR MEDICINE on 10/29/2010 at 12:10 PM]
[Transcribed: jp on 11/03/2010 at 05:12 PM]
[Approved: SANDY ZABROSKI_RN for NUCLEAR MEDICINE, CA on 11/04/2010 at 08:40:38 AM]
[Finalized: 11/04/2010 at 08:40:38 AM]

cc.
W Kirk Harris MD|6981 Littlerock Road, #101|Tumwater, WA 98512

Cardiology Associates, PLLC

William P. Brennan M.D — ***Robert S. Wark M.D.***
William A. Gavin M.D. — ***Craig J. Wehrli M.D.***
Richard P. Kennedy M.D. — ***Christopher L. Wolfe M.D.***
David H. Schoening M.D.

500 Lilly Rd NE
STE 130
Olympia, WA 98506
(360)413-8525
Fax (360) 413-8800

Patient's Name: 4 - Healthcare information readily identifiable to a person - R...
Patient's Phone:
Referring Doctor: ***W. KIRK HARRIS M.D.***
Phone (360)943-3633 fax (360)528-4643
Patient's Insurance: MA
Reason for visit: CP, Pox 94%
Cardiologist preferred: _____

Test or Visit Ordered:

10/29/10
@ 1200

( ) Echocardiogram (93307, 93320, 93325)
( ) Electrocardiogram (93000)
( ) Holter Monitor (93230)
( ) Event Monitor (93268)
( ) Cardiac Consult (99241 99245)
( ) Tredmill (93015)
( ) Stress Echocardiogram (93550, 93015)
(X) Nuclear Cardiolyte Study (78465 78478 78480 99070 A9500)
( ) Other

FAXED
96-
10-4-10
CW

Can the patient exercise? NO
For nuclear study patient's weight 185 *height* 5'3

PATIENT REGISTRATION FORM DATE: 10-04-2010

ACCOUNT NUMBER: 931352-1

PRIMARY PRACTITIONER: 10 W. KIRK HARRIS, M.D.

PERSON RESPONSIBLE FOR BILL:

GUAR NAME:
GUAR ADDRESS: 4 - Healthcare information ...
SUITE APT:
CITY ST ZIP:
GUAR EMPLR: RETIRED

GUAR HOME PHONE: 4 - Healthcare inf...
GUAR WORK PHONE:

PATIENT INFORMATION:

PATIENT NAME:
PATIENT SSN: 4 - Healthcare informati...
DATE OF BIRTH:
PATIENT SEX F
PATIENT EMPLYR RETIRED

PAT HOME PHONE: 4 - Healthcare inf...
PAT WORK PHONE:
AGE: 74
MARITAL STATUS: S
PATIENT ID 4 - He...

REFERRED BY:

INSURANCE INFORMATION:

PRIMARY INS: MEDICARE PART B
POLICY HOLDER 4 - Healthcare information...
EMPLOYER: RETIRED
SUBSCRIBER NO 4 - Healthcare ... A
GROUP NO:
INS COMMENT: $131 DED
BIRTH-DATE: 4 - Healthcar... SEX: F
RELATIONSHIP: SELF

SECONDARY INS: TRICARE FOR LIFE
POLICY HOLDER: TUITELE, MALUA
EMPLOYER: RETIRED
SUBSCRIBER NO: 7 - Personal...
GROUP NO:
INS COMMENT:
BIRTH-DATE: 10 SEX: M
RELATIONSHIP: SELF

* * * Communication Result Report (Oct. 4. 2010 3:38PM) * * *

1) Littlerock Family Medicine
2) W Kirk Harris M. D.

D[redacted]Time: Oct. 4. 2010 3:29PM

File No.	Mode	Destination	Pg(s)	Result	Page Not Sent
0988	Memory TX	4138800	P. 3	OK	

Reason for error
E. 1) Hang up or line fail
E. 2) Busy
E. 3) No answer
E. 4) No facsimile connection
E. 5) Exceeded max. E-mail size

Cardiology Associates, PLLC

William P. Brennan M.D ***Robert S. Wark M.D.***
William A. Gavin M.D. ***Craig J. Wehrli M.D.***
Richard P. Kennedy M.D. ***Christopher L. Wolfe M.D.***
David H. Schoening M.D.

500 Lilly Rd NE
STE 130
Olympia, WA 98506
(360)413-8525
Fax (360) 413-8626

Patient's Name: [redacted]
Patient's Phone [redacted]
Referring Doctor: ***W. KIRK HARRIS M.D.***
Phone (360)943-3633 fax (360)528-4643
Patient's Insurance: MA
Reason for visit: CP, Pox 94%
Cardiologist preferred: _____

Test or Visit Ordered:

( ) Echocardiogram (93307, 93320, 93325)
( ) Electrocardiogram (93000)
( ) Holter Monitor (93230)
( ) Event Monitor (93268)
( ) Cardiac Consult (99241 99245)
( ) Tredmill (93015)
( ) Stress Echocardiogram (93550, 93015)
(X) Nuclear Cardiolyte Study (78465 78478 78480 99070 A9500)
( ) Other

Can the patient exercise? NO
For nuclear study patient's weight 185 *height* 5'3

)LIPS

Lifeline

RECOMMENDATION FORM
REFER TO CODE: WA030

Providence Centralia Lifeline
Program Code:WA030
Amber Fox, Lifeline Coordinator
360-807-7908

Please complete and fax to:
1-360-807-7917

Date _____

TO	
Department	*Providence Centralia Lifeline*
Attention	*Amber Fox, Coordinator*
Phone	*1-360-807-7908*
Fax	*1-360-807-7917*
E-Mail	Amber.fox@providence.org

FROM	
Name	
Company	W. KIRK HARRIS, M.D. 6881 Littlerock Rd. S.W., Suite 101 Tumwater, WA 98512 Ph. 360-943-3633 Fax 360-528-4643
Phone	
Fax	
E-Mail	

Follow-Up Request: ***Please*** let me know the disposition of my referral via: ☐ Phone ☒ Fax ☐ E-mail

Customer Being Referred ☒ Wants to order ☐ Wants more information

First/Last Name: 4 - Healthcare information readily identifiable to a person - RCW 42.5... **Date of Birth:** 4 - Healthcare information rea...

Address: 4 - Healthcare information readily identifiable to a person - RCW 42.56.360(2) and RCW 70.02.020 Apt. #

City: 4 - Healthcare information readily i... County: State 4 - Health... Zip 4 - Healthcare informatio...

Phone 4 - Healthcare information readily identifiable to a person - R...

Coupon Code: AC4 (Free activation and $5 off for 12 months.)

Contact Person *(if other than person being referred)*

Have you spoken to contact person about Lifeline? ☒ Yes ☐ No

Name: Same

Phone ( ) Best Date & Time to Call:

Relationship to Customer:

Special requests:

9-21-10 FXD

3rd Party Notify ☐ (check if you would like fax notification upon subscriber transport to hospital or event). Name to fax notification to:

Fax number:

If you have any questions, please call Customer Sales at 1-800-451-0525 Ext 1534
Lifeline Systems, Inc., 111 Lawrence Street, Framingham, MA 01702-8156 www.lifelinesys.com MD2011-157968-000124

South Sound
Physical & Hand Therapy

www.southsoundtherapy.com

PHYSICAL THERAPY PROGRESS SUMMARY

PATIENT: 4 - Healthcare infor...

DATE: February 2, 2010

DIAGNOSIS: Neck pain

REFERRAL SOURCE: Kirk Harris, M.D.

NUMBER OF SESSIONS COMPLETED: 18

CLAIM NUMBER: 4749130791

Dear Dr. Harris,

SUBJECTIVE: 4 - Healthcare inform... has been seen at South Sound Physical & Hand Therapy for evaluation and treatment of her neck pain. Since the last progress report sent she has been seen for four physical therapy and four massage therapy appointments. She reports a significant relief of neck pain although reports stiffness persists looking to the left more so than the right. She does note waking with tightness in her upper trapezius region. She reports compliance with her home exercise program and indicates she would like to continue with physical therapy to further address neck stiffness.

OBJECTIVE: Cervical spine exam finds left rotation limited to 30° as compared to 45° on the right. End range rotation elicits pulling stiffness pain in the midcervical spine contralaterally. Mild loss of cervical spine extension is noted and a moderate loss of right and left side bending is noted. Mobilizations to the upper cervical spine and the CT junction did significantly improve cervical spine left and right rotation. 4 - Hea... has been instructed in a home exercise program with an emphasis on stretching and muscle energy techniques to improve cervical spine mobility.

ASSESSMENT: 4 - Hea... is making good progress towards goals with reduction in neck pain and headaches. She now presents with stiffness as her primary limitation and is responding favorably to cervical spine joint mobilizations and stretching exercises. Hypomobility in the upper cervical spine is likely the main contributor to rotation range of motion restrictions and hypomobility in the lower cervical spine is contributing to a loss of extension motion. Her prognosis remains excellent and physical therapy is indicated to further address neck stiffness following MVA. 4 - He... has missed physical therapy visits over the past month due to adverse reactions to new medications and a flare-up of inner ear or vertigo symptoms.

TREATMENT PLAN: Physical therapy would like to continue to see patient at two times per week for physical therapy and one time per week for massage therapy. Treatment plan will consist of: 1) Manual therapy including joint mobilizations and soft tissue mobilization. 2) Modalities. 3) A home exercise program. 4) Neck range of motion and strengthening exercises. 5) Postural exercises. 6) Scapular stabilization exercises. 7) Strengthening of deep neck flexors.

Lacey
5210 Corporate Center Ct. SE
Suite D
Lacey, WA 98503
(360) 455-8155
(360) 455-[illegible]655 Fax

East Olympia
360 Lilly Rd. NE
Suite A
Olympia, WA 98506
(360) 486-0640
(360) 486-0641 Fax

Downtown Olympia
111 Market St. NE
Suite 108
Olympia, WA 98501
(360) 754-7085
(360) 754-3671 Fax

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(360) 956-1113 Fax

Tumwater
6981 Littlerock Rd. SW
Suite 105
Tumwater, WA 98512
(360) 352-7352
(360) 352-7680 Fax

FAXED
FEB 10 2010
By KM

GOALS:

1. 4 - Hea... will achieve cervical spine rotation range of motion consistently improved to 60° within four weeks.
2. 4 - Hea... will report relief of contralateral and midcervical spine pain with right and left rotation within four weeks.
3. 4 - Hea... will be independent in a home exercise program to promote continued relief of neck pain and stiffness within four weeks.

Thank you again for this referral. If you have any questions or concerns regarding this patient, feel free to call me at (360) 486-0640.

Sincerely,

Michael Teater, DPT
East Olympia Clinic

MT/ep/eb

Please review the above plan of care and make any changes you feel necessary. Please sign, date, and fax back to us at (360) 486-0641. Thank you.

Physician Date

South Sound
Physical & Hand Therapy

www.southsoundtherapy.com

MASSAGE THERAPY EVALUATION

PATIENT: 4 - Healthcare infor...

EVALUATION DATE: October 23, 2009

DIAGNOSIS: Neck pain.

PRESCRIPTION: Massage therapy.

DATE OF INJURY: September 29, 2009 at a drive-through ATM.

REFERRAL SOURCE: Kirk Harris, M.D.

CLAIM NUMBER: 4749130791

FAXED 11.16.10 CA

Dear Dr. Harris,

HISTORY: Thank you for your referral to South Sound Physical & Hand Therapy. 4 - Hea... is a 73-year-old female that reports to our East Olympia location for evaluation and treatment of her upper back, neck and shoulders. 4 - He... was injured on September 29, 2009, when she was rear-ended while making a deposit sitting at the ATM at the bank. Since the incident, she does report an onset of pain across her upper back and shoulders, into her neck and causing headaches. Additionally, she has noted an onset of tingling of both her right and left hands while doing overhead activities. She reports prior to the accident that she has been seen by her doctor for the onset of tingling in her right hand with studies including an x-ray and MRI; however, results of the imaging studies did not reveal anything. She reports since the accident the left hand has begun tingling in addition to the right hand. She reports the symptoms do affect her ability to sleep throughout the night and reports that she is very tired due to difficulty with sleeping. Also, reports her symptoms are better with rest and worse with turning and twisting. Additionally, she indicates concern or fear with guarding possible damage caused to her neck by being rear-ended in a car accident. Current medications include blood pressure medication and heart medication. Past medical history is remarkable for anxiety disorder, arthritis, bruising easily, depression, diabetes, dizziness, ear infections, heart problems, high blood pressure, shortness of breath and bilateral total hip replacements. Her goal is to return to normal function with improved range of motion in her neck, relieved hand tingling and improved function with sleeping, driving, holding the phone and doing her hair. She would just basically like to regain her self-sufficiency.

OBJECTIVE: During the massage therapy exam, 4 - He... was noted for having hypertonicity in the upper trapezii and suboccipitals. Additional tenderness was found in the levator scapulae, rhomboids, splenius capitis and upper trapezii. Tolerance of pressure is mild and inflicts pain if I go any deeper. Trigger points have not been found yet due to tolerance to pressure being so minimal.

ASSESSMENT: Signs and symptoms are consistent with M.D. diagnosis of neck pain due to cervical strain. Prognosis is excellent. Patient will benefit from massage therapy to promote decreased muscle guarding, decrease pain and decrease the hand tingling. The hand tingling is consistent with thoracic outlet syndrome. Patient also exhibits symptoms of whiplash due to the accident.

Lacey
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Suite D
Lacey, WA 98503
(360) 455-8155
(360) 455-1655 Fax

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(360) 956-1113 Fax

Tumwater
6981 Littlerock Rd. SW
Suite 105
Tumwater, WA 98512
(360) 352-7352
(360) 352-7680 Fax

FAXED NOV 09 2009 By KB

TREATMENT PLAN: 4 - Hea... will be seen for massage therapy once a week for six weeks. Treatment plan will consist of heat pack, soft tissue manipulation, range of motion stretching, myofascial release, and thoracic outlet syndrome treatment techniques.

GOALS: Our goals will be (within six weeks):

1. Decrease the pain level to 2/10 with improved function with activities of daily living.
2. Resolute trigger points if found later within the sessions.
3. Decrease muscle guarding for improved movement.
4. Diminish the hand tingling caused by thoracic outlet syndrome.
5. Bring patients mobility back to 100%.

Thank you again for this referral. If you have any questions or concerns regarding this patient, feel free to call me at (360) 486-0640.

Sincerely,

Kara Gonia, LMP
East Olympia Clinic

KG/ep/jm

Please review the above plan of care and make any changes you feel necessary. Please sign, date, and fax back to us at (360) 486-0641. Thank you.

Physician

3-15-10
Date

FAXED 3.16.10 CA

HARRIS, WILLIAM MD_2011-157968 PAGE 382

State Farm®
Providing Insurance and Financial Services
Home Office, Bloomington, Illinois 61710

November 17, 2009

KIRK HARRIS, MD
6981 LITTLEROCK RD SW STE 101
TUMWATER, WA 98512

Bothell PIP Office
PO BOX 221
DUPONT, WA 98327-0221

RE: Claim Number: 47-4930-791
Date of Loss: 10/6/2009
Our Insured:
Your Patient: 4 - Healthcare information readily id...

Dear Dr. Harris:

It is our understanding you are treating 4 - Healthcare information readily id... for injuries received in an accident on 10/6/2009. Please complete this Physician's Report form on your patient relating to injuries received in this accident. Enclosed is an Authorization to Provide Information signed by 4 - Health... 4 - Healthcare infor...

1. What are the patient's current subjective and objective injuries?

RIGHT NECK PAIN RADIATING INTO THE RIGHT SHOULDER; ALSO HAS HEADACHES. TIGHTNESS IN THE NECK WHEN TURNING HEAD TO THE LEFT. PAIN DOWN POSTERIOR NECK INTO UPPER BACK. TIRED + DEPRESSED ARE THE TIME BECAUSE OF RELATIVE DISABILITY.

2. Please explain how these relate to the motor vehicle accident on 10/6/2009?

WHIPLASH INJURY FROM BEING REAR-ENDED.

3. Have you treated this patient prior to the motor vehicle accident? If so, please list all subjective and objective injuries for which the patient was seen, and the dates of service.

YES.

SEE 3 1/2 YEARS OF PROGRESS NOTES.

W. KIRK HARRIS, M.D.
6981 Littlerock Rd. S.W., Suite 101
Tumwater, WA 98512
Ph. 360-943-3638
Fax 360-528-4843

4. Are the subjective and objective complaints related to any prior condition or other incident? If so, please state what percent of the treatment currently provided is due to the motor vehicle accident.

TINGLING IN THE RIGHT FINGERS.
5/09 C-SPINE MRI SHOWED MULTI-LEVEL DEGENERATIVE DISK DISEASE.

100% OF CURRENT TREATMENT IS PROVIDED DUE TO MVA.

5. Please list your treatment plan. This should include type of treatment, frequency, and length.

MUSCLE RELAXING MEDICATION DAILY.
HOME EXERCISE PROGRAM DAILY.
SUPERVISED PHYSICAL + MASSAGE THERAPY PROGRAM THREE TIMES WEEKLY

6. Has the patient reached maximum medical improvement as related to this loss? If not, please project a future maximum medical improvement date.

HAS NOT REACHED M.M.I.
MAY TAKE 3-6 MONTHS

W. KIRK HARRIS, M.D.
6981 Littlerock Rd. S.W., Suite 101
Tumwater, WA 98512
Ph. 360-943-3633
Fax 360-526-4643

Physician's Name _____

Physician's Signature _____ MD Date 12-10-09

Payment consideration of any/all outstanding bills will pend our receipt and review of the requested information.

We appreciate your time.

South Sound
Physical & Hand Therapy

www.southsoundtherapy.com

LIGHT PRESS AT FIRST.

MASSAGE THERAPY EVALUATION

PATIENT: 4 - Healthcare infor...

EVALUATION DATE: October 23, 2009

DIAGNOSIS: Neck pain.

CAN'T CHANGE BED.

PRESCRIPTION: Massage therapy.

↑ VACUUM

DATE OF INJURY: September 29, 2009 at a drive-through ATM.

↑ PRESSURE SOAK

REFERRAL SOURCE: Kirk Harris, M.D.

↑ CLEAN HANDS

CLAIM NUMBER: 4749130791

90° HEAD TURN LIMITS DRIVING

Dear Dr. Harris,

APPT NEEDS LONG IN AM FINISH TIMING

HISTORY: Thank you for your referral to South Sound Physical & Hand Therapy. 4 - He... is a 73-year-old female that reports to our East Olympia location for evaluation and treatment of her upper back, neck and shoulders. 4 - Healt... was injured on September 29, 2009, when she was rear-ended while making a deposit sitting at the ATM at the bank. Since the incident, she does report an onset of pain across her upper back and shoulders, into her neck and causing headaches. Additionally, she has noted an onset of tingling of both her right and left hands while doing overhead activities. She reports prior to the accident that she has been seen by her doctor for the onset of tingling in her right hand with studies including an x-ray and MRI; however, results of the imaging studies did not reveal anything. She reports since the accident the left hand has begun tingling in addition to the right hand. She reports the symptoms do affect her ability to sleep throughout the night and reports that she is very tired due to difficulty with sleeping. Also, reports her symptoms are better with rest and worse with turning and twisting. Additionally, she indicates concern or fear with guarding possible damage caused to her neck by being rear-ended in a car accident. Current medications include blood pressure medication and heart medication. Past medical history is remarkable for anxiety disorder, arthritis, bruising easily, depression, diabetes, dizziness, ear infections, heart problems, high blood pressure, shortness of breath and bilateral total hip replacements. Her goal is to return to normal function with improved range of motion in her neck, relieved hand tingling and improved function with sleeping, driving, holding the phone and doing her hair. She would just basically like to regain her self-sufficiency.

OBJECTIVE: During the massage therapy exam, 4 - He... was noted for having hypertonicity in the upper trapezii and suboccipitals. Additional tenderness was found in the levator scapulae, rhomboids, splenius capitis and upper trapezii. Tolerance of pressure is mild and inflicts pain if I go any deeper. Trigger points have not been found yet due to tolerance to pressure being so minimal.

ASSESSMENT: Signs and symptoms are consistent with M.D. diagnosis of neck pain due to cervical strain. Prognosis is excellent. Patient will benefit from massage therapy to promote decreased muscle guarding, decrease pain and decrease the hand tingling. The hand tingling is consistent with thoracic outlet syndrome. Patient also exhibits symptoms of whiplash due to the accident.

Lacey
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Lacey, WA 98503
(360) 455-8155
(360) 455-1655 Fax

East Olympia
360 Lilly Rd. NE
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(360) 486-0640
(360) 486-0641 Fax

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111 Market St. NE
Suite 108
Olympia, WA 98501
(360) 754-7085
(360) 754-3571 Fax

West Olympia
1651 Cooper Point Rd. SW
Olympia, WA 98502
(360) 956-1100
(360) 956-1113 Fax

Tumwater
6981 Littlerock Rd. SW
Suite 105
Tumwater, WA 98512
(360) 352-7352
(360) 352-7680 Fax

TREATMENT PLAN: Joyce will be seen for massage therapy once a week for six weeks. Treatment plan will consist of heat pack, soft tissue manipulation, range of motion stretching, myofascial release, and thoracic outlet syndrome treatment techniques.

GOALS: Our goals will be (within six weeks):

1. Decrease the pain level to 2/10 with improved function with activities of daily living.
2. Resolute trigger points if found later within the sessions.
3. Decrease muscle guarding for improved movement.
4. Diminish the hand tingling caused by thoracic outlet syndrome.
5. Bring patients mobility back to 100%.

Thank you again for this referral. If you have any questions or concerns regarding this patient, feel free to call me at (360) 486-0640.

Sincerely,

Kara Gonia, LMP
East Olympia Clinic

KG/ep/jm

Please review the above plan of care and make any changes you feel necessary. Please sign, date, and fax back to us at (360) 486-0641. Thank you.

_____ _____

Physician Date

South Sound
Physical & Hand Therapy
www.southsoundtherapy.com

PHYSICAL THERAPY PROGRESS SUMMARY

PATIENT: 4 - Healthcare infor... DATE: February 2, 2010

DIAGNOSIS: Neck pain.

REFERRAL SOURCE: Kirk Harris, M.D.

NUMBER OF SESSIONS COMPLETED: 18

CLAIM NUMBER: 4749130791

Dear Dr. Harris,

SUBJECTIVE: 4 - Healthcare infor... has been seen at South Sound Physical & Hand Therapy for evaluation and treatment of her neck pain. Since the last progress report sent she has been seen for four physical therapy and four massage therapy appointments. She reports a significant relief of neck pain although reports stiffness persists looking to the left more so than the right. She does note waking with tightness in her upper trapezius region. She reports compliance with her home exercise program and indicates she would like to continue with physical therapy to further address neck stiffness.

OBJECTIVE: Cervical spine exam finds left rotation limited to 30° as compared to 45° on the right. End range rotation elicits pulling stiffness pain in the midcervical spine contralaterally. Mild loss of cervical spine extension is noted and a moderate loss of right and left side bending is noted. Mobilizations to the upper cervical spine and the CT junction did significantly improve cervical spine left and right rotation. 4 - Health... has been instructed in a home exercise program with an emphasis on stretching and muscle energy techniques to improve cervical spine mobility.

ASSESSMENT: 4 - Hea... is making good progress towards goals with reduction in neck pain and headaches. She now presents with stiffness as her primary limitation and is responding favorably to cervical spine joint mobilizations and stretching exercises. Hypomobility in the upper cervical spine is likely the main contributor to rotation range of motion restrictions and hypomobility in the lower cervical spine is contributing to a loss of extension motion. Her prognosis remains excellent and physical therapy is indicated to further address neck stiffness following MVA. 4 - Hea... has missed physical therapy visits over the past month due to adverse reactions to new medications and a flare-up of inner ear or vertigo symptoms.

TREATMENT PLAN: Physical therapy would like to continue to see patient at two times per week for physical therapy and one time per week for massage therapy. Treatment plan will consist of: 1) Manual therapy including joint mobilizations and soft tissue mobilization. 2) Modalities. 3) A home exercise program. 4) Neck range of motion and strengthening exercises. 5) Postural exercises. 6) Scapular stabilization exercises. 7) Strengthening of deep neck flexors.

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(360) 956-1113 Fax

Tumwater
6981 Littlerock Rd. SW
Suite 105
Tumwater, WA 98512
(360) 352-7352
(360) 352-7680 Fax

GOALS:

1. 4 - Hea... will achieve cervical spine rotation range of motion consistently improved to 60° within four weeks.
2. 4 - Hea... will report relief of contralateral and midcervical spine pain with right and left rotation within four weeks.
3. 4 - Hea... will be independent in a home exercise program to promote continued relief of neck pain and stiffness within four weeks.

Thank you again for this referral. If you have any questions or concerns regarding this patient, feel free to call me at (360) 486-0640.

Sincerely,

Michael Teater, DPT
East Olympia Clinic

MT/ep/eb

Please review the above plan of care and make any changes you feel necessary. Please sign, date, and fax back to us at (360) 486-0641. Thank you.

_____ _____

Physician Date

South Sound
Physical & Hand Therapy

www.southsoundtherapy.com

PHYSICAL THERAPY PROGRESS SUMMARY

PATIENT: 4 - Healthcare inform...

DATE: December 30, 2009

DIAGNOSIS: Neck pain.

REFERRAL SOURCE: Kirk Harris, M.D.

NUMBER OF SESSIONS COMPLETED: 14

CLAIM NUMBER: 4749130791

FAXED 01.13.10

Dear Dr. Harris,

SUBJECTIVE: 4 - Healthcare infor... is being seen at South Sound Physical & Hand Therapy for evaluation and treatment of her neck pain. She reports overall decreased neck pain and decreased frequency of headaches. She does continue to have good and bad days, however reports primarily having stiffness more than pain in her neck. She notes her neck is more stiff currently than prior to the car accident and she would like to continue with physical therapy to continue progress towards goals.

OBJECTIVE: Cervical spine exam finds right and left rotation limited to 45° with Joyce reporting pulling on the opposite side of the direction she is rotating. When rotating her neck to the left, she does note pain elicited in the mid cervical spine. Right and left side bending active range of motion is limited to 20° bilaterally, and extension active range of motion is limited to 30°. Hypomobility noted in the lower cervical spine. Hypertonicity noted in the cervical spine paraspinals, right greater than left sternocleidomastoid, bilateral scalenes and suboccipitals. Pressure to the suboccipitals does elicit mild headache symptoms.

ASSESSMENT: 4 - He... is making good progress towards goals with decreased neck pain and decreased headaches. She is having improved tolerance to exercises in physical therapy. Due to the holidays, she has missed the last two weeks of therapy and will benefit from resuming therapy on a more regular basis to expedite progress towards goals of restoring a baseline level of cervical spine range of motion, further relief of neck pain and headaches, and home exercise program independence. Her prognosis remains excellent.

TREATMENT PLAN: Physical therapy would like to continue to see patient at 2-3 times per week for four weeks with massage therapy at one time per week for four weeks. Treatment plan will consist of: 1) Manual therapy, 2) Modalities, 3) Home exercise program, 4) Neck range of motion and strengthening exercises, 5) Postural exercises, 6) Scapular stabilization exercises and strengthening of deep neck flexors.

FAXED By JAN 06 2010

GOALS:

1. 4 - Hea... will have cervical spine rotation improved to 60° bilaterally within four more weeks.
2. 4 - He... will have decreased tenderness in the cervical spine musculature indicative of tissue healing within four weeks.

Lacey
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Suite D
Lacey, WA 98503
(360) 455-8155
(360) 455-1655 Fax

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(360) 956-1113 Fax

Tumwater
6981 Littlerock Rd. SW
Suite 105
Tumwater, WA 98512
(360) 352-7352
(360) 352-7680 Fax

3. 4 - Heal... will be independent in a home exercise program to optimize cervical spine strength and range of motion within four weeks.

Thank you again for this referral. If you have any questions or concerns regarding this patient, feel free to call me at (360) 486-0640.

Sincerely,

Michael Teater, DPT
East Olympia Clinic

MT/ep/jm

Please review the above plan of care and make any changes you feel necessary. Please sign, date, and fax back to us at (360) 486-0641. Thank you.

Harris, MD 1-13-10

Physician Date

South Sound
Physical & Hand Therapy

www.southsoundtherapy.com

PHYSICAL THERAPY PROGRESS SUMMARY

PATIENT: 4 - Healthcare infor... DATE: December 30, 2009

DIAGNOSIS: Neck pain.

REFERRAL SOURCE: Kirk Harris, M.D.

NUMBER OF SESSIONS COMPLETED: 14

CLAIM NUMBER: 4749130791

Dear Dr. Harris,

SUBJECTIVE: 4 - Healthcare infor... is being seen at South Sound Physical & Hand Therapy for evaluation and treatment of her neck pain. She reports overall decreased neck pain and decreased frequency of headaches. She does continue to have good and bad days, however reports primarily having stiffness more than pain in her neck. She notes her neck is more stiff currently than prior to the car accident and she would like to continue with physical therapy to continue progress towards goals.

OBJECTIVE: Cervical spine exam finds right and left rotation limited to 45° with 4 - Heal... reporting pulling on the opposite side of the direction she is rotating. When rotating her neck to the left, she does note pain elicited in the mid cervical spine. Right and left side bending active range of motion is limited to 20° bilaterally, and extension active range of motion is limited to 30°. Hypomobility noted in the lower cervical spine. Hypertonicity noted in the cervical spine paraspinals, right greater than left sternocleidomastoid, bilateral scalenes and suboccipitals. Pressnue to the suboccipitals does elicit mild headache symptoms.

ASSESSMENT: 4 - He... is making good progress towards goals with decreased neck pain and decreased headaches. She is having improved tolerance to exercises in physical therapy. Due to the holidays, she has missed the last two weeks of therapy and will benefit from resuming therapy on a more regular basis to expedite progress towards goals of restoring a baseline level of cervical spine range of motion, further relief of neck pain and headaches, and home exercise program independence. Her prognosis remains excellent.

TREATMENT PLAN: Physical therapy would like to continue to see patient at 2-3 times per week for four weeks with massage therapy at one time per week for four weeks. Treatment plan will consist of: 1) Manual therapy, 2) Modalities, 3) Home exercise program, 4) Neck range of motion and strengthening exercises, 5) Postural exercises, 6) Scapular stabilization exercises and strengthening of deep neck flexors.

GOALS:

1. 4 - Healt... will have cervical spine rotation improved to 60° bilaterally within four more weeks.
2. 4 - Hea... will have decreased tenderness in the cervical spine musculature indicative of tissue healing within four weeks.

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Tumwater
6981 Littlerock Rd. SW
Suite 105
Tumwater, WA 98512
(360) 352-7352
(360) 352-7680 Fax

 4 - Healthcare informat... Progress Summary 12.30.09 L&I# 4749130791

3. 4 - Hea... will be independent in a home exercise program to optimize cervical spine strength and range of motion within four weeks.

Thank you again for this referral. If you have any questions or concerns regarding this patient, feel free to call me at (360) 486-0640.

Sincerely,

Michael Teater, DPT
East Olympia Clinic

MT/ep/jm

Please review the above plan of care and make any changes you feel necessary. Please sign, date, and fax back to us at (360) 486-0641. Thank you.

Physician Date 1-6-10

South Sound
Physical & Hand Therapy

FAXED

www.southsoundtherapy.com

PHYSICAL THERAPY PROGRESS SUMMARY

PATIENT: 4 - Healthcare infor...

DATE: November 20, 2009

DIAGNOSIS: Neck pain.

REFERRAL SOURCE: Kirk Harris, M.D.

NUMBER OF SESSIONS COMPLETED: 7

CLAIM NUMBER: 4749130791

Dear Dr. Harris,

SUBJECTIVE: 4 - Healthcare infor... has been seen at South Sound Physical & Hand Therapy at our East Olympia location for evaluation and treatment of her neck pain. She reports good and bad days with her neck pain; however, currently neck pain is decreased with primary complaints of stiffness. She does report compliance with her home exercise program and notes turning her head right is more stiff and painful than turning left. She reports physical therapy is helping with helping to decrease her neck pain, and she would like to continue with physical therapy to continue progress towards goals.

OBJECTIVE: Cervical spine exam finds right and left rotation limited to 45°. Palpation exam finds hypertonicity and tenderness in bilateral scalenes and SCM cervical spine musculature. 4 - Hea... does present with thoracic spine kyphosis and hypomobility of the thoracic spine, placing increased strain on her cervical spine. Upper cervical spine rotation range of motion is equal bilaterally.

ASSESSMENT: 4 - Hea... has made excellent progress towards goals since beginning physical therapy with improved cervical spine active range of motion, decreased neck pain, decreased headaches, improved sleeping tolerance and decreased hand tingling with overhead activities. She will benefit from continuing with physical therapy to normalize cervical spine rotation active range of motion, to improve thoracic mobility, to improve strength of spinal stabilizers and postural musculature, to promote home exercise independence, and to prevent recurrence of symptoms. Her prognosis remains excellent.

TREATMENT PLAN: Physical therapy would like to continue to see patient at 2-3 times per week for four weeks with massage therapy at one time per week for four weeks. Treatment plan will consist of: 1) Manual therapy, 2) Modalities, 3) A home exercise program, 4) Spinal range of motion and strengthening exercises, 5) Postural exercises, 6) Scapular stabilization exercises and strengthening of deep neck flexors.

GOALS:

1. 4 - Hea... will have cervical spine rotation active range of motion improved to 60° bilaterally within 4-6 weeks with abolished end-range pain.
2. 4 - Hea... will have abolished hypertonicity and tenderness in the bilateral scalenes and sternocleidomastoid indicative of adequate tissue healing within six weeks.

Lacey
5210 Corporate Center Ct. SE
Suite D
Lacey, WA 98503
(360) 455-6155
(360) 455-1655 Fax

East Olympia
360 Lilly Rd. NE
Suite A
Olympia, WA 98506
(360) 486-0640
(360) 486-0641 Fax

Downtown Olympia
111 Market St. NE
Suite 108
Olympia, WA 98501
(360) 754-7085
(360) 754-3671 Fax

West Olympia
1651 Cooper Point Rd. SW
Olympia, WA 98502
(360) 956-1100
(360) 956-1113 Fax

Tumwater
6981 Littlerock Rd. SW
Suite 105
Tumwater, WA 98512
(360) 352-7352
(360) 352-7680 Fax

3. ... 4 - Heal... will be independent in a home exercise program to prevent recurrence of symptoms within 4-6 weeks.

Thank you again for this referral. If you have any questions or concerns regarding this patient, feel free to call me at (360) 486-0640.

Sincerely,

Michael Teater, DPT
East Olympia Clinic

MT/ep/jm

Please review the above plan of care and make any changes you feel necessary. Please sign, date, and fax back to us at (360) 486-0641. Thank you.

Physician

11-30-09
Date

Empi
599 Cardigan Road
St. Paul, Minnesota 55126-4099
651-415-9000; 800-328-2536

3000608

Dear Physician:
In order to ensure accurate claims submission and the continued usage of your patient's Empi device, we must have documentation to support the medical necessity of the product and any related supplies. ***Please provide the information requested below.***

PHYSICIAN'S STATEMENT OF MEDICAL NECESSITY/PRESCRIPTION

PLEASE COMPLETE, SIGN, DATE AND RETURN IN THE ENCLOSED ENVELOPE, OR FAX TO 800-450-3593

Account # 4119407
Patient Name
Address
City/State/Zip
Social Security #

4 - Healthcare information readily identifiable t...

Patient Requires: EMPI 4 LEAD TENS AND SUPPLIES

Date of Issue: 10-28-2009 Date of Onset/Injury:

ICD-9 Code(s): C-SPINE STRAIN 847.0

Previous Treatment(s)/Medication(s): MEDICATION, HOME EXERCISE, SUPERVISED PHYSICAL THERAPY

Estimated Length of Need:
- ☐ Lifetime, (Purchase)
- ☒ 6 - 9 Months, (Long-term Need)
- ☐ ____ Months (Please Enter # of Months)

I certify that the medical necessity information noted-above is true, accurate and complete to the best of my knowledge.

Physician's Signature: Harris, MD Date: 11-12-09

W. KIRK HARRIS, M.D.
6981 Littlerock Rd. S.W., Suite 101
Tumwater, WA 98512
Ph. 360-943-3633
Fax 360-528-4643

HARRIS KIRK W MD
6981 LITTLEROCK RD
TUMWATER, WA 98512

UPIN# E29955
360/943-3633
REF# 354427
Ret to: CHAROLOTTE PENA

801008 Rev. U, © 1995, 2002 Empi 8/02

Dr. Kirk Harris

Open 9 to 5

quality medical care

6981 Littlerock Road SW, Ste. 101
Tumwater, WA 98512
360-943-3633
fax: 360-528-4643
NPI:1588662068

Date: 10.27.09
To: Mike
FAX: 360.412.0219
From: LFM
Regarding: 4 - Healthcare information readily identifiable to a person - ...
Person Faxing: CA
Pages

2 including fax sheet

Mike
360 412-0219

WILLIAM HARRIS, MD

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Law Offices of.

Harold D. Carr, P.S.

Attorneys at Law

A Professional Service Corporation

www.haroldcarrattorney.com

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Leslie Lueck • Martin Barnett • Shirley McKay
Jenny Yanasak • Mayra Pena • Cindy Angelo

10065

4535 Lacey Blvd SE Lacey, WA 98503 • Phone: 360-455-0030 • Fax: 360-455-0031 • Tax I.D. # 91-1508016

October 26, 2009

Kirk W. Harris, M.D.
Attn: Patient Records / Bills
6981 Littlerock Road., Ste. 101
Tumwater, WA 98512

Re: Personal Injury Claim : 4 - Healthcare information rea...
Date of accident : **9/29/2009**
Date of Birth : 4 - Healthcare info...

Dear Patient Accounts:

My office represents 4 - Healthcare information re... in connection with a claim for injuries sustained on 9/29/2009, as a result of an accident.

My client expressly authorizes you to forward any requested treatment reports and medical bills directly to my client's own insurance carrier so that may secure benefits under either Health Insurance or Personal Injury Protection (PIP) coverage.

***Do not send medical records or billing at this time.** We will request these items on a later date.

Please submit Billing to:

State Farm Insurance
Attn: Team PH
P.O. Box 221
Dupont, WA 98327

Policy Holder: 4 - Healthcare information rea...

Claim #: 47-4930-791

My client revokes any other medical release authorization, with the exception of PIP or health insurance releases.

Thank you in advance for your prompt attention to this matter. Please do not hesitate to call me with any specific questions or comments you may have.

Sincerely,

HDC rm

Harold D. Carr

HDC:rm

WH READ CAREFULLY

Neurosurgery
Robert G. R. Lang, M.D., Inc., P.S.

3525 Ensign Rd NE, Suite J • Olympia, WA 98506
Telephone (360) 491-0459 • Fax (360) 491-5370

Robert G. R. Lang, M.D.,
F.R.C.S. (C), F.A.C.S.

Rebecca Peterson,
M.S.N., A.R.N.P.

June 16, 2009

Kirk Harris, M.D.
6981 Littlerock Rd. SW
Tumwater, WA 98512

RE: 4 - Healthcare information readi...

Dear Dr. Harris:

Thank you for asking us to see this pleasant, 73 year old, right-handed female with complaints of right hand tingling.

HISTORY OF PRESENT ILLNESS: Ms. 4 - Healt... first noted tingling in her right hand, primarily the thumb, approximately two months in the past. She initially thought the symptoms were related to arthritis, however, the tingling would also include the entire hand at times. She noted that the tingling was not affecting her grip strength. She had concerns that the tingling could be related to vascular problems as two of her sisters have had blockages in the arteries of the neck and two other sisters have had aneurysms.

The tingling is primarily in the right thumb but at times extends up the arm to just above the elbow. The tingling does not occur in the left hand or arm. If she holds her hand upright flexed at the elbow the tingling occurs. She tends to sleep with her hand up under the pillow and does not notice the tingling occurring at that time. She has no pain in her neck or shoulder and has not had any headaches. She has had no problems with balance or coordination. She feels that she has been more cautious when walking since her hip surgery several years in the past. She has been taking indomethacin routinely for her arthritic pain.

PAST MEDICAL HISTORY: She had TB as a teenager and was treated while living in Scotland. She has hypertension, hypercholesterolemia, a cardiac murmur and depression. Surgical history includes left hip replacement in 2001, right hip replacement in 2003 followed by acute renal failure and right tympanoplasty in 1969.

Current medications include atenolol 1 qd, Lisinopril 1 qd, HCTZ I qd, indomethacin qd, Prozac qd and Lovastatin qd. She also takes another heart pill but does not recall the name. She has sensitivity to codeine which causes her to feel dopey.

SOCIAL HISTORY: She is a widow with two adult children. She moved to the Olympia area several years in the past from California. She was born and raised in Scotland and moved to the United States as a young adult. She retired in 1995 as a general manager for a hotel chain. She graduated from high school and has two years of college education. She has never smoked and does not drink alcohol. Her hobbies include knitting, reading and sewing.

FAMILY HISTORY: Her father died at age 78 from heart disease and CVA. Her mother died from a thrombus. Other family history includes CHF, CVA, heart disease, aneurysms and TB.

Suggests EMG's

REVIEW OF SYSTEMS: She rates her general health and well being as good and gets mild exercise. She has difficulty sleeping which is not related to her hand symptoms, nervousness, lightheadedness, hard of hearing, intermittent discharge from her right ear, her heart races or skips beats intermittently, heart murmur and hypertension. She was treated for TB as a teenager. She has stiff, painful, swollen joints, arthritis in her hands, gout in her right middle toe. She has diet controlled diabetes and has lost approximately 50 lbs since being diagnosed with diabetes. She has passed through menopause.

PHYSICAL EXAMINATION: This is a well developed right-handed female 5'3" tall weighing approximately 175 lbs. She declined to be weighed today. Heart rate is 66 and regular without holosystolic murmur. Blood pressure is 132/30. Carotid bruits are heard bilaterally, right stronger than left. Her lungs are clear and respiration non labored. The abdomen was soft and nontender, no palpable masses, no hepatosplenomegaly. She is alert and answers questions appropriately. Speech is clear.

Palpation of the cervical region reveals no localized tenderness. No muscle spasms are noted. She can flex her chin to her chest, extend to 30°, laterally flex 30° bilaterally and rotation to 70° right, 50° left. Shoulder abduction is to 180° bilaterally. Tricep, bicep and brachioradialis reflexes are depressed bilaterally. There is weakness of opposition bilaterally. Otherwise both arms are strong. Tinel's test at the wrist and elbow is negative bilaterally. Phalen's test is negative bilaterally. Vibration and temperature sensations are equal. Pinprick sensation is diminished on the tip of the right thumb. Hoffman's sign is negative bilaterally.

Gait is mildly widebased and slight stiff. Tandem gait is unsteady. Patellar and ankle reflexes are depressed bilaterally. Toes were downgoing. Tone was normal in the lower extremities. No clonus is noted.

RADIOLOGICAL FINDINGS: The report from the cervical MRI performed 5/14/09 was reviewed by myself and Dr. Lang. The films were not available. The radiologist reports 2 mm of anterolisthesis at C3 on C4 and C4 on C5. There arc multilevel degenerative changes throughout the cervical region. At C3-4 there is moderate broad disk bulging and facet degenerative changes. There is marked severe right and moderate left neuroforaminal narrowing without significant central canal stenosis. At C4-5 there is a disk osteophyte complex with moderate facet degenerative changes. There was effacement of the ventral aspect of the thecal sac. Mild to moderate right and moderate to severe left neuroforaminal narrowing is reported. At C5-6 moderate to large circumferential disk osteophyte complex is reported with bilateral facet degenerative changes causing moderate to severe spinal stenosis with resultant deformity of the spinal cord. No cord abnormalities are reported. The neuroforamen are narrowed bilaterally. At C6-7 there is small broadbased disk bulging and facet degeneration with only mild neuroforaminal narrowing.

DIAGNOSIS: She has central canal stenosis at C5-6 and has signs of myelopathy. She has carotid bruits and stenosis should be assessed.

RECOMMENDATIONS: The history was reviewed with Dr. Lang and he also examined the patient. We have ordered cervical flexion/extension x-rays to assess for abnormal motion. We would recommend a carotid doppler or MRA of the cervical arteries if these have not already been performed. She will follow-up with Dr. Lang after the x-rays.

Sincerely,

Robert G.R. Lang, M.D.
RGRL:slm

Rebecca J. Peterson, ARNP
RJP:slm

Authorization for Release of Information

Claim Number: 47-4930-791 P

I, 4 - Healthcare information readil... , authorize the following providers:

1. DR. KIRK HARRIS
2. DR. ROBERT LANG
3. _____
4. _____

to provide relevant information, including

1. my medical and dental records (history, treatment, diagnosis, prognosis, billings) and/or
2. my earnings, loss of earnings, work history and medical information in their possession to

State Farm Mutual Automobile Insurance Company and its affiliates (hereinafter "State Farm"), and its claim or legal representatives.

I understand my records may be protected under federal and state confidentiality regulations and my express consent may be required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, mental illness, or mental health treatment and/or alcohol abuse treatment. I hereby specifically authorize you to release all health care information relating to such diagnosis, testing, or treatment, if such information exists, to State Farm.

Automobile insurance does not fall within the definition of "health plan" in the privacy rules developed pursuant to the Health Insurance Portability and Accountability Act of 1996 (hereinafter known as HIPAA).

This information should be provided to State Farm representatives who are evaluating and/or processing a pending claim, as a result of my involvement in an alleged accident that occurred on or about ~~10/6/2009~~ 09/29/2009.

This authorization may be revoked at any time, except to the extent that State Farm has taken action in reliance on this authorization prior to notice of revocation. Such revocation must be in writing, dated, signed, and include the claim number referenced above. I understand that revocation of this authorization may potentially cause a delay in processing. Or result in the denial of, insurance benefits for the pending injury claim(s).

This authorization is valid for the duration of the claim, and I agree a photocopy of it is as valid as the original.

It is my understanding that treatment I have received from my medical providers has not been conditioned upon my signing this authorization. I further understand and authorize that, as part of the claim handling process, State Farm may disclose medical information obtained by this authorization to physicians, dentists or healthcare providers for evaluation. Information obtained pursuant to this authorization may later be redisclosed and may not be protected under the HIPAA privacy rules.

I have read this authorization and understand that State Farm will send me a copy of any records provided to State Farm pursuant to the use of this authorization, upon receiving my written request, provided the information requested can lawfully be disclosed to me.

I release any person or organization that provides information to State Farm as authorized herein from all legal responsibility or liability that may arise from the release of this information.

"Washington law requires us to notify you of the following:"

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Signature: 4 - Healthcare information readily identifiable to a person - R... Social Security Number: 4 - Healthcare information readily identifiable to a p...

(Patient, employee or authorized representative) *(For provider's use in locating records)*

Date: 10/19/09 Date of birth: 2/10/09

130130 Rev. 08-01-2006

Authorization to Release Health Care Information

Patient's name: 4 - Healthcare information readily identifiable to a person - RCW 42.56... Date of Birth: 4 - Healthcare information rea...

SSN: 4 - Healthcare information readily identifiable to a person - RCW 42.... Previous Name: _____

Previous Health Care Provider/Doctor:

Name: DR KARL MOLIM

Mailing Address: KENDAL ST

City: VACAVILLE State: CA Zip Code: 95688

I request and authorize ~~DR KIRK HARRIS~~ KARL MOLIM to release health care information of the patient named above to :

W. Kirk Harris, M.D.
6981 Littlerock RD SW #101
Tumwater, WA 98512
360-943-3633 telephone
360-528-4643 fax

mailed 6/29/06 mjl

This request and authorization applies to:

☐ Health care information relating to the following treatment, condition, or dates of

☐ treatment: _____

☒ All health care information.

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS VIRUS), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating the such diagnosis, testing or treatment.

4 - Healthcare information readily identifiable to a person - RCW 42.56.360(2) and RCW 70.02.020

Signature of patient or patient's authorized representative — Date signed 6/27/06

Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative, etc.)

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER THE DATE IT IS SIGNED

4 - Healthcare information readily identifiable to a pe...

NOV 29 2005

wt 264
B/P 132/70
Temp 98.5

C.C: Stuffed up, coughing, sore throat.

HT 69 1/2

GEN

EYES N

EARS N

NECK N

RESP. URI, hypertension

LUNGS N

C.V. N

ABD. N

SKIN N

sister has a stroke

Flu Shot

KARL E. MOLIN, M.D.

11-29-05 flu shot 0.5 ml (LD) deltoid Lot
U186AA exp 30 Jun 06

KARL E. MOLIN M.D. INC
313 KENDAL STREET
VACAVILLE, CA 95688
(707) 448-8471

4 - Healthcare information readily identifiable to a p...

FEB 27 2006

Q% 3 mo check up.

BP 136/70
HT 265
WT 270

LUNGS Clear

C.V. RRR

ABD. N

SKIN N

EYES N

EARS N

NECK N

KARL E. MOLIN M.D. INC
313 KENDAL STREET
VACAVILLE, CA 95688
(707) 448-8471

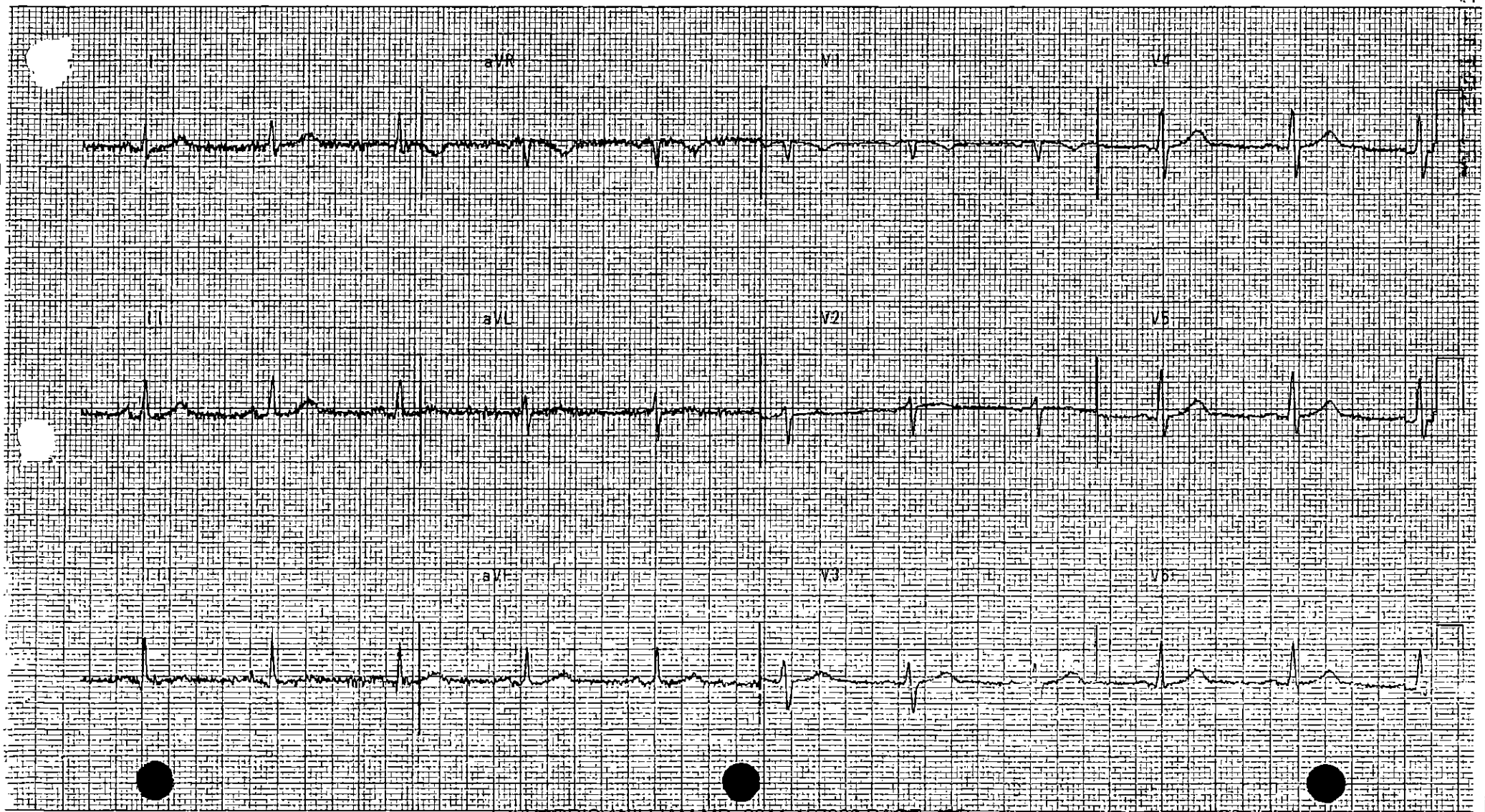
Name 4 - Healthcare informatio...
ID 559606603
69YR Female

SINUS RHYTHM
NORMAL ECG

KARL C. MOHR, M.D.

10/24/05
03:11 ~~11/16/37~~

Vent	Durations			Axes		
Rate	PR	QRS	QT/QTC	P	QRS	T
63	160	100	404/412	80	72	48



OCT 24 2005 C/o palpatations, pain on left shoulder.
BP 132/70 when she takes a deep breath she
Wt 260 feels a bit of stiffness.
Age 69 C/O Lt shoulder pain - for a second or so - a
Temp 98.2 twinge. Laying on the rt side can make it
more. Sometimes she has dyspnea

LUNGS Clear

EYES N C.V. Reg

EARS N ABD. N

INF. N SKIN N

Chestwall shoulder pain. ECG - WNL

Dexa scan - Mammogram.

Use ASA prn.

KARL E. MOLIN M.D. INC
313 KENDAL STREET
VACAVILLE, CA 95688
(707) 448-8471

4 - Healthcare information readily identifiable to a person - RCW 42.56.3...

APR 28 2005

Ht 267

B/P RS 140/80
90

P 80

3 month re ✓
Med refills

AGE 69

EYES N

N

NECK N

CVS. RURES Clear

C.V. RRR

ABD. N

SKIN N

MED. Hypertension, Hyperlipidemia, Depression

Pt request Mammogram again

Atenolol 50 30
+ daily

HCTZ 25 30
② + daily

Lisinopril 20 30
+ daily ②

↑ Zocor 30 30
+ daily.
②

3 mo ret

KARL E. MOLIN, M.D.

Mammogram ordered
#30

AUG 1 1 2005

4 - Healthcare information readily identifiable to a person - RCW 42.56.3...

wt 262

B/P 144/72 132/70

P 72

[redacted] 69

[redacted]

EYES N

EARS N

NECK N

[redacted] Hypertension

3 month follow up
Hypertension Hyperlipidemia
(RB) Depression, Also been having
neck pain

LUNGS Clear

C.V. RRR

ABD. N

SKIN N

She may be moving to Olympia Washington

Atenolol 1 daily	50	32
HCTZ 1 daily	25	32
Lisinopril 1 daily	20	30
Zocor 1 daily	40	30

→ Fluoxetine 20 mg 30
2 1 daily

Diclofenac 75 mg
#30
1 PC pain joint pain

Mammogram ordered

(2)

KARL E. MOLIN M.D. INC
313 KENDAL STREET
VACAVILLE, CA 95688
(707) 448-8471

4 - Healthcare information readily identifiable to a person - RCW 42.56...

JAN 1 4 2005

Wt 264

B/P 108/74 138/70

P 80

Wt 268

3 months re Hypertension

RP Shoulder pain

GEN. Felt very well.

EYES N

EARS N

NECK N

CVD Controlled BP.

LUNGS Clear

C.V. Reg

ABD. N

SKIN N

does well off of fluoretic.

Stop Celebrex

ordered

mammogram

Duracan

Lipid panel

— Flu Shot —

.5cc

(L) U1470AA
Influenza Virus Vaccine
Preservative-free, Pediatric Dose
US Govt Lic #1277
Mfd by: Aventis Pasteur Inc
Swiftwater PA 18370 USA
CPT® Code: 90655

0.25 mL
2004 - 2005 Formula
Rx only
4962

given @ deltoid sor
Exp 6/05/

KARL E. MOLIN M.D. INC
313 KENDAL STREET
VACAVILLE, CA 95688
(707) 448-8471

4 - Healthcare information readily identifiable to a person - RCW ...

SEP 1 7 2004

Wt 244

B/P 138/82

2 month re v

Hyperlipidemia

Pt has decided to D.C. Finasteride

P 72

A: WD

LUNGS Clear

LYES N

C.V. RRR

EARS N

ABD. N Obese

NECK N

SKIN Skin wound on buttock has completely healed.

Hypertension.
Obesity

Lipid panel.

D.C. Finasteride

Clonidine + daily	50	30
HCTZ + daily	25	30
Lisinopril + daily	40	30
Zocor + daily	20	30
Celebrex + daily	200	30

+ refills

KARL E. MOLIN, M.D.

4 - Healthcare information readily identifiable to a ...

JUL 15 2004

WT 233

BP 146/74 154/80

P 68

C.C. review meds & discuss meds & Zocor

HEENT

LUNGS Clear

EYES N

C.V. RRR

EARS N

ABD. N

INFC N

SKIN tiny pea size lesion remains at gluteal fold.

HX hyperlipidemia

Zocor 1 tablet daily	20	30
Amlodipine 1 tablet daily	20	30
Atenolol 1 tablet daily	25	30
Atenolol 1 tablet daily	50	30
Aspirin 1 tablet daily	325	30

2 refills

She goes to Scotland & England in Oct.

advanced directives discussed

KARL E. MOLIN, M.D.

4 - Healthcare information readily identifiable to a person - RCW ...

APR 15 2004

Wt 231 —

B/P 124/82 —

P 72 T 97.6

Re ~ Decubitus ulcer
need refills

HEENT WNL

EYES N

EARS N

NECK N

LUNGS Clear

C.V. RRR

ABD. N

SKIN Pt's decubitus ulcer is healing well & clear of infection

MP. Hypertension

BLOOD

Lisinopril 20 mg 1 daily	20	30	
Atenolol 50 mg 1 daily	50	30	Celebrex 200 mg #30
HCTZ 25 mg 1 daily	25	30	
Finasteride 5 mg 1 daily	20	30	+ PC ? potential drug interaction

Urine 12, Lipids, Urine

KARL E. MOLIN M.D. INC
313 KENDAL STREET
VACAVILLE, CA 95688
(707) 448-8471

4 - Healthcare information readily identifiable to a perso...

FEB 09 2004
wt unable
BP 120/64
P 80

CC: Pt states here for post op visit. Now has decub & red peri area.

AGE: 67 yrs

HEENT:

EYES: N

EARS: N

NECK: N

LUNGS: Clear

C.V. RRR

ABD. N

SKIN: N except Pt has a 5 cm diameter stage 2 decubitus

MS: Decubitus ulcer at gluteal fold

Nystatin powder to perineum

Pt states hip is healing well & has no pain

Referral to wound care center will be mad. a visiting nurse cleanes it every other day.

HCC 4 tsp 20%
1 pt
1 TBSP in juice
daily

MD 2011-157968-PAGE

4 - Healthcare information readily identifiable to a person - RC...

JAN 2 9 2004

Pt unsteady on feet

BP 138/82

PR T. 98.5

AGE 67

GEN Alert oriented.

EYES N

EARS N

NECK N

RESP. Decupitus ulcer 2

CBC, Chem 7

Hold of Simvastatin
- Atenolol 50 qd.
- HCTZ 25 qd.
- Lisinapril 10 mg qd.
- Fluoxetine 20 mg qd.
- Lovenox

2nd Post Op visit
(L) Hip replacement 1-9-04
Nav hx bedsore buttocks
+ (L) lower leg ankle + foot
swelling, headaches

LUNGS Clear

C.V. RRR

ABD. N good BM's no diarrhea.

SKIN

Pt has a superficial bed decupitus.

Pt's hip & back do not hurt.

Pt ambulates with 1 walk.

967 Mabury Road
San Jose, CA 95133
1 (408) 288-9850
1 (8[illegible] 98-8008

3714 Northgate Blvd.
Sacramento, CA 95834
1 (916) [illegible]7-9900
1 (800) [illegible]-5691

Patient: [redacted] 4 - Healthcare information readily ... 4 - Healthcare informatio...
Age/DOB: 67, [redacted]
Sex: F

4503245 1001
Client: KARL MOLIN, M.D.

313 KENDAL STREET
VACAVILLE, CA 95688

707-448-8471

Accession No: 6L5317853
Collected: 01/06/04 10:05
Received: 01/06/04 14:00
Reported: 01/07/04 08:30
Re-reported:
Report Status: FINAL
Page:

FASTING

Test	In Range	Out of Range	Reference	Units	PF
SODIUM, SERUM	144		135-146	mmol/L	SC
POTASSIUM, SERUM	4.0		3.5-5.3	mmol/L	SC
CHLORIDE, SERUM	103		98-110	mmol/L	SC
CARBON DIOXIDE (CO2)	22		21-33	mmol/L	SC
UREA NITROGEN,BLOOD (BUN)	25		7-30	mg/dL	SC
CREATININE, SERUM		1.7 H	0.5-1.2	mg/dL	SC
GLUCOSE	91		65-109	mg/dL	SC
CBC WITH DIFFERENTIAL (AUTOMATED)					
WHITE BLOOD COUNT	7.1		3.8-10.8	Thous/mcL	SC
RED BLOOD COUNT	4.62		3.80-5.10	Mill/mcL	SC
HEMOGLOBIN	14.8		11.7-15.5	g/dL	SC
HEMATOCRIT	43.2		35.0-45.0	%	SC
MCV	94		80.0-100.0	fL	SC
MCH	32.1		27.0-33.0	pg	SC
MCHC	34.3		32.0-36.0	g/dL	SC
RED CELL DIST. WIDTH	11.5		11.0-15.0	%	SC
DIFFERENTIAL TYPE	AUTO				SC
NEUTROPHILS	51		45 - 73	%	SC
LYMPHOCYTES	40		20 - 43	%	SC
MONOCYTES	6		1 - 13	%	SC
EOSINOPHILS	3		0 - 6	%	SC
BASOPHILS	0		0 - 2	%	SC
NEUTROPHILS (ABS VALUE)	3.62		1.50-7.80	Thous/mcL	SC
LYMPHOCYTES (ABS VALUE)	2.86		0.80-3.90	Thous/mcL	SC
MONOCYTES (ABS VALUE)	0.40		0.20-0.95	Thous/mcL	SC
EOSINOPHILS (ABS VALUE)	0.186		0.015-0.500	Thous/mcL	SC
BASOPHILS (ABS VALUE)	0.000		0.000-0.200	Thous/mcL	SC
PLATELET COUNT	285		140-400	Thous/mcL	SC

PERFORMING SITE

SC - Quest Diagnostics, 3714 Northgate Boulevard, Sacramento, CA 95834
Gerald E. Simon, M.D., (800) 952-5691

LAST PAGE OF REPORT MD 2011-157968-000221

Quest Diagnostics
967 Mabury Road
San Jose, CA 95133
1 [illegible] 288-9850
1 [illegible]8245
3714 Northgate Blvd.
Sacramento, CA 95834
(916) 927-9900
(800) 952-5691

Patient Name: [illegible] 69, [illegible] 4 - Healthcare information readily i... 4 - Healthcare informa...
Age/DOB: [illegible]
Sex: F
PHONE #: 4 - Healthcare information re...
SS #: NOT GIVEN

Client: KARL MOLIN, M.D.
313 KENDAL STREET
VACAVILLE, CA 95688

MOLIN, KARL E.
707-448-8471

Accession No: GN4020834
Collected: 04/20/05 09:45
Received: 04/20/05 15:00
Reported: 04/21/05 08:10
Re-reported:
Report Status: FINAL
Page: 1

Requisition #: Not Given

Test	In Range	Out of Range		Reference	Units	PS
LIPID PROFILE						
CHOLESTEROL, TOTAL		218	H	<200	mg/dL	SC
TRIGLYCERIDES		236	H	<150	mg/dL	SC
VLDL CHOLESTEROL (CALCULATED)		47	H	5 - 40	mg/dL	SC
LDL CHOLESTEROL (CALCULATED)		137	H	0 - 129	mg/dL	SC
CHOLESTEROL, HDL		34	L	>40	mg/dL	SC
CHOLESTEROL/HDL RATIO		6.4	H	AVE. RISK 4.5-5.5		SC
CARDIAC RISK FACTOR:		ABOVE AVERAGE RISK				
LDL/HDL RATIO	4.03 AVERAGE RISK			AV.RISK 2.34-4.13		SC

KARL E. MOLIN, M.D.

PERFORMING SITE

SC - Quest Diagnostics, 3714 Northgate Boulevard, Sacramento, CA 95834
Gerald E. Simon, M.D., (800) 952-5691

LAST PAGE OF REPORT

GN4020834 4 - Healthcare information readily ...

Faxed 1-05-04 427-6257

HISTORY AND PHYSICAL

Name	Age	Date of Exam	Date of Surgery
4 - Healthcare information readily identifiable to a ...	67	1-5-04	1-9-04

Chief Complaint: Severe (R) hip pain Dr - Koford

Present Illness:

Past History:

	Yes	No	Specify if Yes:
Operations	☒	☐	Rt hip age 65, Tympanoplasty 34
Transfusions	☐	☒	
Injuries	☐	☒	
Illnesses	☒	☐	To age 20, hypertension, hyperlipidemia, Depression
Allergies	☐	☒	
Family History/Illness	☐	☐	Father CVA age 83 d/t, Mother died ?? of HA

LMP _____ Habits _____

Medications Atenolol 50 qd, Lisinopril 20 qd, Fluoxetine 20 qd, Zocor 10 mg qd, HCTZ 25 qd Vioxx 12.5 qd prn.

Review of Systems:

HEENT: -0-

Cardiovascular: -0-

Pulmonary: -0-

Renal: -0-

Other: Rt c/o Lt hip pain.

Physical Exam:

Height	Weight	Temp	Heart Rate	Respirations	Blood Pressure
5'4"	252	97.5	80	20	114/72

	Non-Contributory	Other		Non-Contributory	Other
HEENT	☐	dental care seen	Abdominal	☑	
Neck	☐	2+ 3/6 bruit over carotids	Pelvis	☐	refused
Chest	☑		Rectal	☐	refused
Heart	☑		Extremities	☑	
Breasts	☑		Neurological	☑	
Lungs	☑		Lymphatics	☑	

Impression: Lt hip degenerative changes hypertension, hyperlipidemia, Depression

Labs: Age 0 - 39: HCT | 40 - 64: HCT, Creat, Glu, EKG | 64 & over: HCT, Creat, Glu, EKG-Normal, CXR

Procedure Plan: _____

Pre-Op Orders: _____

_____

_____

_____

_____ M.D.

Physician's Signature

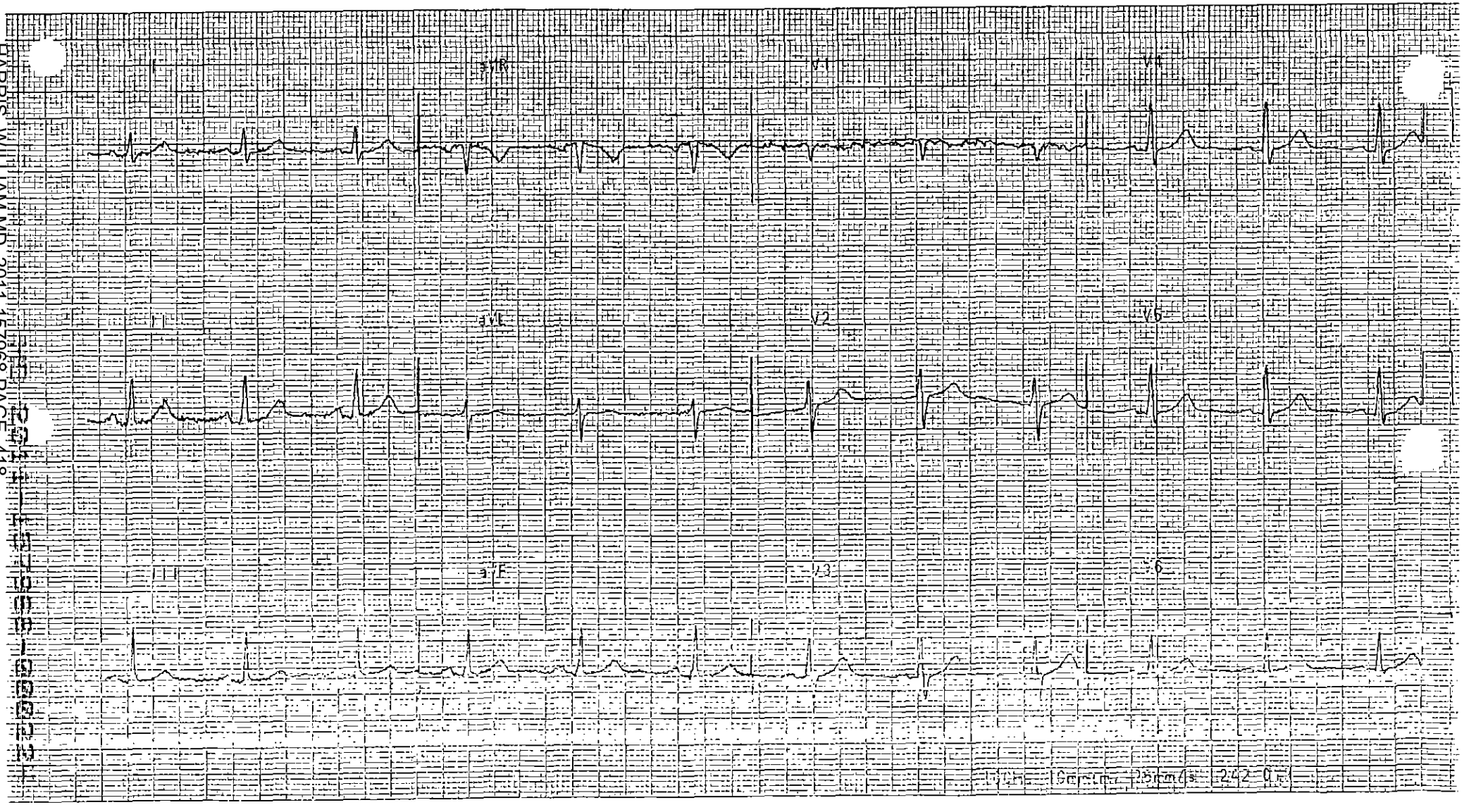
MD 2011-157968-000229

Name [redacted]
ID 55[redacted]6603
67YR Female

SINUS RHYTHM
NORMAL ECG

13:40 01/05/04

Vent Rate	Durations PR	QRS	QT/QTC	Axes P	QRS	T
70	168	88	380/401	72	79	56



HARRIS, WILLIAM MD_2011-157968 PAGE 418

JAN 05 2004

Age: 67 almost 68

252

B/P 114/72

Pre-Op H+P

(R) hip replacement

DOS scheduled for 1-9-04

Dr Kofod NB Hospital

DATE 1-5-4

Patient [redacted] Address [redacted] AGE

Rx	CANCEL UNUSED LINES	mg / % sol	No. / cc	LABEL DIRECTIONS:	Number Refills
1	[illegible]	20	30	[illegible]	
2	[illegible]	[illegible]	[illegible]	[illegible]	
3	[illegible]	[illegible]	[illegible]		

Number of Drugs Prescribed Above ____

Pharmacy Use Only:

CAUTION: If form appears photo copied [illegible]

DATE 1-5-4

Patient [redacted] Address [redacted] AGE

Rx	CANCEL UNUSED LINES	mg / % sol	No. / cc	LABEL DIRECTIONS:	Number Refills
1	[illegible]	2%	30	[illegible]	
2	[illegible]	[illegible]	30	[illegible]	
3	[illegible]	20	30	[illegible]	

Number of Drugs Prescribed Above ____

Label Drug # ____

Do Not Drink ☐ Do Not Drive ☐

Control Number [illegible]

Pharmacy Use Only:

CAUTION: If form appears photo copied, void is obvious or background is not pink, verify script before filling.

Scriptech®

4 - Healthcare information readily identifiable to a person - RC...

SEP 2 2 2003

256

B/P 138/82

P 72

67

3 month re ✓ Hypertension
(LH) hip pain requesting referral to Dr Kofod

LUNGS N

C.V. N

ABD. N

SKIN N

Degenerative arthritis of hip(L)
Obesity
Hypertension.

Referral to Dr Kofod for consideration of Lt hip total replacement

Lt hip was replaced 2 yrs ago she was told the Lt hip needed replacement also.

KARL E. MOLIN, M.D.

JUN 05 2003

4 - Healthcare information readily identifiable to a person - RCW 42.56.360(2) ...

wt 257

HT 5'4"

B/P 132/82 P72

3 month re- Hb p
has not got blood work done

Ht. 67

GEN.

EYES N

EARS N

NECK N

JUNGS Clear

C.V. RRR

ABD. N Obese

SKIN N

ENDO. hypertension

reorder CBC, Chem 7, Lipids UA

Atenolol 50 1 po qd x 30 2

Lipitor 10 1 po qd x 30 2

Norvasc 5 1 po qd x 30 2

Prilosec 20 1 po qd x 30 2

KARL E. MOLIN, M.D.

MAR 10 2005

4 - Healthcare information readily identifiable to a perso...

Ht 5'4"

258

B/P 150/80 142/70

P 72

CC: pt state here to re-V B/P + renew meds.

AGE 67

OPN

EYES N

EARS N

NECK N

LUNGS Clear

C.V. RRR

ABD. N

SKIN N

HT. hypertension.

CBC, chem 7, Lipids, UA

husband died 12-24-3.

return 3 mo

KARL E. MOLIN, M.D.

DEC 1 0 2002

4 - Healthcare information readily identifiable to a person - RCW 42.56.360...

ht 247

BP 100/62

P 72

CC: back pain chest pain vomiting + diarrhea x 1 week fatigue She had diarrhea + some vomiting - better now

T. 97.7.

by denies Abd pain

LUNGS Clear

EYES N

C.V. N

EARS N

ABD. Soft/nontender

NECK N

SKIN N

Prob Abd. Gastroenteritis.

order CBC, Chem 12, ?, Liquids

Mammogram

Doc #8

2

2

2

2

2

KARL E. MOLIN, M.D.

4 - Healthcare information readily identifiable to ...

Wt 254
Bp 138/84
p 64

cc HTN - Follow up
Rx refill

64

N

N

N

LUNGS Clear

C.V. RRR

ABD N

SKIN N

M hypertension, Depression

KARL E. MOLIN, M.D.

4 - Healthcare information readily identifiable to a person - RCW ...

JUN 1 1 2002

ut 251 cc: Rx refill

p 1/68/88 Pt had a rt hip replacement + is much better c the rt hip pain. The Lt hip hurts a bit a times. She ran out of pills & has not taken them today.

66

HEENT

EYES N

EARS N

NECK N

LUNGS Clear

C.V. RRR

ABD. N

SKIN N

- hypertension
- Rt hip Surgery

no wt loss - no wt watchers

KARL E. MOLIN, M.D.

return 3 mo.

VACAVILLE IMAGING CENTER

A RadNet Center

600 Nut Tree Road, Suite 110
Vacaville, CA 95687
Toll Free: (800) 894-7226
Phone: (707) 452-7226
Fax: (707) 452-8422

A.O. Rawal, M.D.M.S.
Medical Director

Magnetic Resonance Imaging, MRA,
Hi Speed CT, Ultrasound, Mammography,
Digital Fluoroscopy, Diagnostic Radiology

X-RAYS OF THE RIGHT HIP

Date of Examination: 10-02-01

PATIENT: 4 - Healthcare information readil...

BIRTH DATE: 4 - Healthcar...

PATIENT ID: 00-12565

REFERRING PHYSICIAN:
Karl Molin, M.D.
313 Kendal Street
Vacaville, CA 95688

The films were checked out by the patient for the clinical treatment team and have not been returned; therefore, at this time they are unread.

A.O. RAWAL, M.D.

AOR:DMR
D: 03-27-02
T: 03-27-02

look for these

Sent letter to pt re x-rays 4/8/02

KARL E. MOLIN, M.D.

RADNET MANAGEMENT, INC.
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VACAVILLE IMAGING CENTER

A RadNet C.

600 Nut Tree Road, Suite 110
Vacaville, CA 95687
Toll Free: (800) 894-7226
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Fax: (707) 452-8422

Jerry Jacob Parker, M.D.
Medical Director

Magnetic Resonance Imaging
Computed Tomography
Diagnostic Radiology

X-RAY OF THE RIGHT KNEE

Date of Examination: 09/27/00

PATIENT: 4 - Healthcare information rea...

BIRTH DATE: 4 - Healthca...

PATIENT ID: 00-12565

REFERRING PHYSICIAN:
Karl Molin, M.D.
313 Kendal Street
Vacaville, CA 95688

CLINICAL HISTORY: Rule out osteoarthritis.

EXAMINATION FINDINGS:

There are marked degenerative changes between the patella and distal femur. There is also bony spurring of the distal femur, proximal tibia, and tibial spine. There is no evidence of swelling within the knee joint. No acute bony abnormalities are delineated.

IMPRESSION:
Moderate to moderately severe degenerative changes of the knee with the degenerative changes most pronounced between the patella and distal femur.

Douglas Tait, M.D., Inc.

KARL E. MOLIN, M.D.

DT:jcd
D&T: 09/28/00

4 - Healthcare information readily identifiable to a person -...

JAN 07 1991 cc: Follow up on Blood pressure.
Wt. 220 She's feeling heart palpations. She
BP 142/90 later 140/88 feels that she is a very anxious
P 104 person. Pt notices palpitations at times.
She has had a lot of stress — her job has had a major change. She denies chest pain.

AGE 54

GEN.

NOSE N

EYES N

EARS N

NECK N

MTH N

THRO N

LUNGS Clear

CV - reg tach one skipped beat

Abd. N no murmurs

IMP. Palpitations, hypertension

PLAN

ECG - WNL

Continue current BP meds.

schedule Holter monitor.

KARL E. MOLIN, M.D.

JAN 14 1991
KARL E. MOLIN, M.D. Holter monitor

JAN [illegible] cc: Holter results

WT - N/A
BP - 134/90 later 150/90 Pt c/o noticing
P - 80 palpitations quite often. Pt never
gets asthma
Rx palpitations
D.C. Vasotec & HCTZ Start Tenormin 50

KARL E. MOLIN M.D.

Date: DEC 0 9 2010

Telephone: 447-3243

Name: 4 - Healthcare information readily identifiable to a pers...

Age: 54

DOB: 4 - Healthcare infor...

BP: 162/98 P: 92 R: ET: WT: 223 Temp:

Chief Complaint: BP ✓ & med.

Illnesses: Tb at age 21 — has lungs scars treated c INH/Rifampin & Streptomycin

Injuries:

Surgeries: Ear operation - 1969
Dorsalectomy - 1952
Rt hip - Rt total hip 10-2001

Medications: Vasotec & Nexium 10mg 1 qd.

Allergies: penicillan & codeine

GYN: 2 Gr: 2 Para: Ab: LMP: 1987

Last Pap: 1989
Birth Control:

Family History: 2 sisters died of brain aneurysm

Smoke: Ø

ETOH: rarely

Occupation: manager - Brigadoon

Marital Status: legally separated

In case of emergency contact: Jean Juliff
Telephone: 447-3243

Formerly Dr Moss Pt

54 years.

HEENT N

THRT N

NECK N

LUNGS Clear

CV - RRR

Gr 2/6

ABD N

EXT N

NEURO N

SKIN N

IMP hypertension
history of Tb & scarred lungs

PLAN

KARL E. MOLIN, M.D.

MD 2011-157968-000235

Case File_5748_pdf-r.pdf redacted on: Wednesday, July 18, 2012

Redaction Summary (728 redactions)

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7 Privilege / Exemption reasons used:

1 -- "DOH Licensee Health Professional home address and/or phone - RCW 42.56.350(2)" (4 instances)

2 -- "DOH Licensee Social Security Number - RCW 42.56.350(1)" (1 instance)

3 -- "Healthcare Integrity and Protection Data Bank information or National Practitioner Data Bank Information – RCW 42.56.510, 45 CFR 61.14" (7 instances)

4 -- "Healthcare information readily identifiable to a person - RCW 42.56.360(2) and RCW 70.02.020" (657 instances)

5 -- "Identity - Whistleblower and whistleblower's healthcare information - RCW 42.56.510, RCW 43.70.075, RCW 42.56.360(2) and RCW 70.02.020" (1 instance)

6 -- "Identity - Whistleblower and whistleblower's healthcare information - RCW 42.56.510, RCW 43.70.075, RCW 42.56.360(2) and RCW 70.02.020" (56 instances)

7 -- "Personal information - Social security number - RCW 42.56.510" (2 instances)

Redacted pages:

Page 15, DOH Licensee Health Professional home address and/or phone - RCW 42.56.350(2), 1 instance
Page 15, Identity - Whistleblower and whistleblower's healthcare information - RCW 42.56.510, RCW 43.70.075, RCW 42.56.360(2) and RCW 70.02.020, 1 instance
Page 16, Identity - Whistleblower and whistleblower's healthcare information - RCW 42.56.510, RCW 43.70.075, RCW 42.56.360(2) and RCW 70.02.020, 1 instance
Page 22, Identity - Whistleblower and whistleblower's healthcare information - RCW 42.56.510, RCW 43.70.075, RCW 42.56.360(2) and RCW 70.02.020, 1 instance
Page 24, Healthcare Integrity and Protection Data Bank information or National Practitioner Data Bank Information – RCW 42.56.510, 45 CFR 61.14, 3 instances
Page 26, Identity - Whistleblower and whistleblower's healthcare information - RCW 42.56.510, RCW 43.70.075, RCW 42.56.360(2) and RCW 70.02.020, 1 instance
Page 28, Identity - Whistleblower and whistleblower's healthcare information - RCW 42.56.510, RCW 43.70.075, RCW 42.56.360(2) and RCW 70.02.020, 8 instances
Page 30, Identity - Whistleblower and whistleblower's healthcare information - RCW 42.56.510, RCW 43.70.075, RCW 42.56.360(2) and RCW 70.02.020, 2 instances
Page 31, Identity - Whistleblower and whistleblower's healthcare information - RCW 42.56.510, RCW 43.70.075, RCW 42.56.360(2) and RCW 70.02.020, 1 instance
Page 33, Identity - Whistleblower and whistleblower's healthcare information - RCW 42.56.510, RCW 43.70.075, RCW 42.56.360(2) and RCW 70.02.020, 1 instance
Page 38, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
Page 39, Identity - Whistleblower and whistleblower's healthcare information - RCW 42.56.510, RCW 43.70.075, RCW 42.56.360(2) and RCW 70.02.020, 3 instances
Page 41, Identity - Whistleblower and whistleblower's healthcare information - RCW 42.56.510, RCW 43.70.075, RCW 42.56.360(2) and RCW 70.02.020, 2 instances
Page 42, Identity - Whistleblower and whistleblower's healthcare information - RCW 42.56.510, RCW 43.70.075, RCW 42.56.360(2) and RCW 70.02.020, 2 instances
Page 44, Identity - Whistleblower and whistleblower's healthcare information - RCW 42.56.510, RCW 43.70.075, RCW 42.56.360(2) and RCW 70.02.020, 1 instance
Page 46, Healthcare information readily identifiable to a person - RCW 42.56.360(2) and RCW 70.02.020, 2 instances
Page 46, Identity - Whistleblower and whistleblower's healthcare information - RCW 42.56.510, RCW 43.70.075, RCW 42.56.360(2) and RCW 70.02.020, 6 instances
Page 48, Healthcare information readily identifiable to a person - RCW 42.56.360(2) and RCW 70.02.020, 2 instances
Page 49, Healthcare information readily identifiable to a person - RCW 42.56.360(2) and RCW 70.02.020, 1 instance
Page 52, Healthcare information readily identifiable to a person - RCW 42.56.360(2) and RCW 70.02.020, 1 instance
Page 53, Healthcare information readily identifiable to a person - RCW 42.56.360(2) and RCW 70.02.020, 4 instances
Page 54, Healthcare information readily identifiable to a person - RCW 42.56.360(2) and RCW 70.02.020, 1 instance
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Page 59, Healthcare information readily identifiable to a person - RCW 42.56.360(2) and RCW 70.02.020, 1 instance
Page 62, Healthcare information readily identifiable to a person - RCW 42.56.360(2) and RCW 70.02.020, 5 instances
Page 65, Healthcare information readily identifiable to a person - RCW 42.56.360(2) and RCW 70.02.020, 1 instance
Page 66, DOH Licensee Health Professional home address and/or phone - RCW 42.56.350(2), 2 instances
Page 66, Identity - Whistleblower and whistleblower's healthcare information - RCW 42.56.510, RCW 43.70.075, RCW 42.56.360(2) and RCW 70.02.020, 2 instances
Page 68, Healthcare information readily identifiable to a person - RCW 42.56.360(2) and RCW 70.02.020, 3 instances
Page 69, Healthcare information readily identifiable to a person - RCW 42.56.360(2) and RCW 70.02.020, 1 instance
Page 70, Healthcare information readily identifiable to a person - RCW 42.56.360(2) and RCW 70.02.020, 3 instances
Page 71, Healthcare information readily identifiable to a person - RCW 42.56.360(2) and RCW 70.02.020, 1 instance
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Page 81, Healthcare information readily identifiable to a person - RCW 42.56.360(2) and RCW 70.02.020, 4 instances
Page 82, Healthcare information readily identifiable to a person - RCW 42.56.360(2) and RCW 70.02.020, 2 instances
Page 82, Identity - Whistleblower and whistleblower's healthcare information - RCW 42.56.510, RCW 43.70.075, RCW 42.56.360(2) and RCW 70.02.020, 1 instance
Page 83, Healthcare information readily identifiable to a person - RCW 42.56.360(2) and RCW 70.02.020, 1 instance

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